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the Canadian Nurse

VOLUME 58 • NUMBER 1

MONTREAL

JANUARY, 1962

HIGHLIGHTS

MILLER — The Patient's Right to Know the Truth

KNOWLES — How our Behavior Affects Patient Care

KLASSEN — Stokes-Adams Syndrome

NICHOLSON — Nursing Care in Stokes-Adams Syndrome

SOLOMON — The Professional School in the University

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Between Ourselves

The week of June 24-29 should be encircled on every Canadian nurse's calendar. That is the period when the Biennial meeting of our national association is being held in Vancouver. PRESIDENT HELEN CARPENTER, in her annual New Year message, gives us brief glimpses of the important program that is being developed for our convention. Between now and next June other authors will tell us more about the progress that has been made during this biennium in fulfilling the recommendations from the Pilot Project report that were approved at the 1960 convention.

What do all of these developments mean to each of us? Why should it be a matter of interest and concern to us as individuals to learn what courses of action that large organization, the Canadian Nurses' Association, plans? "I am a member of the Registered Nurses' Association of Ontario — or Nova Scotia — or Saskatchewan. What does the CNA mean to me?"

It was a distinct shock to us, recently when the director of a school of nursing — she teaches the course in professional adjustments to the senior students, by the way — told us that she was not at all clear on the question of how a nurse became a member of the Canadian Nurses' Association! If she was vague about it, it is highly probable that there are many other nurses who are not sure. There is not room in this column to give you anything more than a thumb-nail sketch of how the association developed, but here it is.

Antedating the organization of the first provincial nurses' association by a number of years, the graduates of many schools of nursing had formed themselves into alumnae associations which were partly social, partly professional in their goals. Because, even 60 years ago, there was a tendency for nurses to gravitate to the urban areas to work, a sprinkling of nurses' "clubs" gradually grew up in various cities. When the first national association was formed in 1908, it was a loosely knit amalgam of these alumnae and local associations. Membership in either of the latter groups carried with it membership in the national body.

That same principle of dual membership still prevails. As provincial nurses' associations were organized, they absorbed the local groups into their plan of organization. Today, we know them as chapters. By the early thirties, the influence of the alumnae associations had waned to the point that membership in the Canadian Nurses' Association was limited to those nurses who held membership in their provincial association. Thus, in nine provinces, when you renew your membership and pay your fees for your annual re-registration, you are at the same time paying your fee for membership in the CNA. Only in Ontario are re-registration and provincial association membership separate entities. Every nurse in that province who pays the additional membership fee to belong to her professional organization receives the same national membership the rest of Canadian nurses enjoy.

So it is *our* convention that is being held in Vancouver. It is *our* destiny as a professional group that comes under review. It is *our* responsibility as nurses to know what transpires during that week in June. It is the privilege of every one of the more than 60,000 members of the CNA to be present in the Queen Elizabeth Auditorium in Vancouver. Of course, we won't all be there! But let us make the attendance this year the largest in the annals of our association. Three thousand? That would mean only 5 per cent of our total membership.

An advance registration form will be found on page 45. Be among the first to file yours!

* * *

What do you feel about the matter of patients being told the truth about an unpleasant, direful diagnosis? The opinions that DR. A. MILLER presents would seem to indicate that there is a greater reluctance on the part of many members of the medical profession to reveal the true state of the condition than there is on the part of the majority of patients to be told. Has this been your experience?

In the days when the typical unit in our society was an isolated farm family engaged in relatively simple economic pursuits, there may have been little premium on the communicating ability of the average individual. Today, when almost no man works alone and none is self-sufficient, the ability to exchange ideas and thoughts effectively is a prime requisite. Without adequate skills in this field no one is equipped to cope with a world of change. — RONALD S. RITCHIE

THE CANADIAN NURSE

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JANUARY 1962

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Dr. Miller is clinical director of the Ontario Hospital for Mental Diseases, Toronto, Ontario.

30 HOW OUR BEHAVIOR AFFECTS PATIENT CARE.....*L. N. Knowles*

Miss Knowles is assistant dean and associate professor in the College of Nursing, University of Florida, Gainsville, Fla.

34 STOKES-ADAMS SYNDROME.....*G. A. Klassen*

Dr. Klassen was the assistant resident in charge of the cardiopulmonary unit, Royal Victoria Hospital, Montreal when this article was written.

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Miss Nicholson was the nurse in charge of the in-patient service of the Cardiopulmonary Unit of the Royal Victoria Hospital, Montreal when this report was written.

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Dr. Solomon is an Associate Professor in the department of Sociology and Anthropology, McGill University, Montreal.

56 CRAZY OR COURAGEOUS.....*M. A. Sutherland*

Miss Sutherland, who learned a new language by working for a year in a large French hospital, was on the staff of the Women's Pavilion, Royal Victoria Hospital when she wrote this article.

58 YOU HAVEN'T GOT YOUR BED WARM YET!.....*G. W. Isaac*

Mr. Isaac lives in Bowden, Alberta.

60 SICK VISITING IS AN ART.....*C. Field*

Mrs. Field is a nursing instructor, at the General Hospital, Hamilton, Ontario.

61 HE WHO LAUGHS, LASTS.....*D. M. Dent*

Miss Dent, formerly a Civil Service Health Consultant in Ottawa, is now devoting much of her time to a new career as a writer.

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Th views expressed in the various articles are the views of the authors and do not necessarily represent the policy or views of THE CANADIAN NURSE *nor of the Canadian Nurses' Association.*

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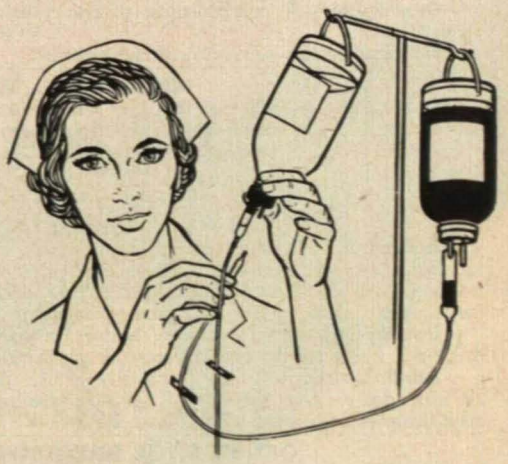
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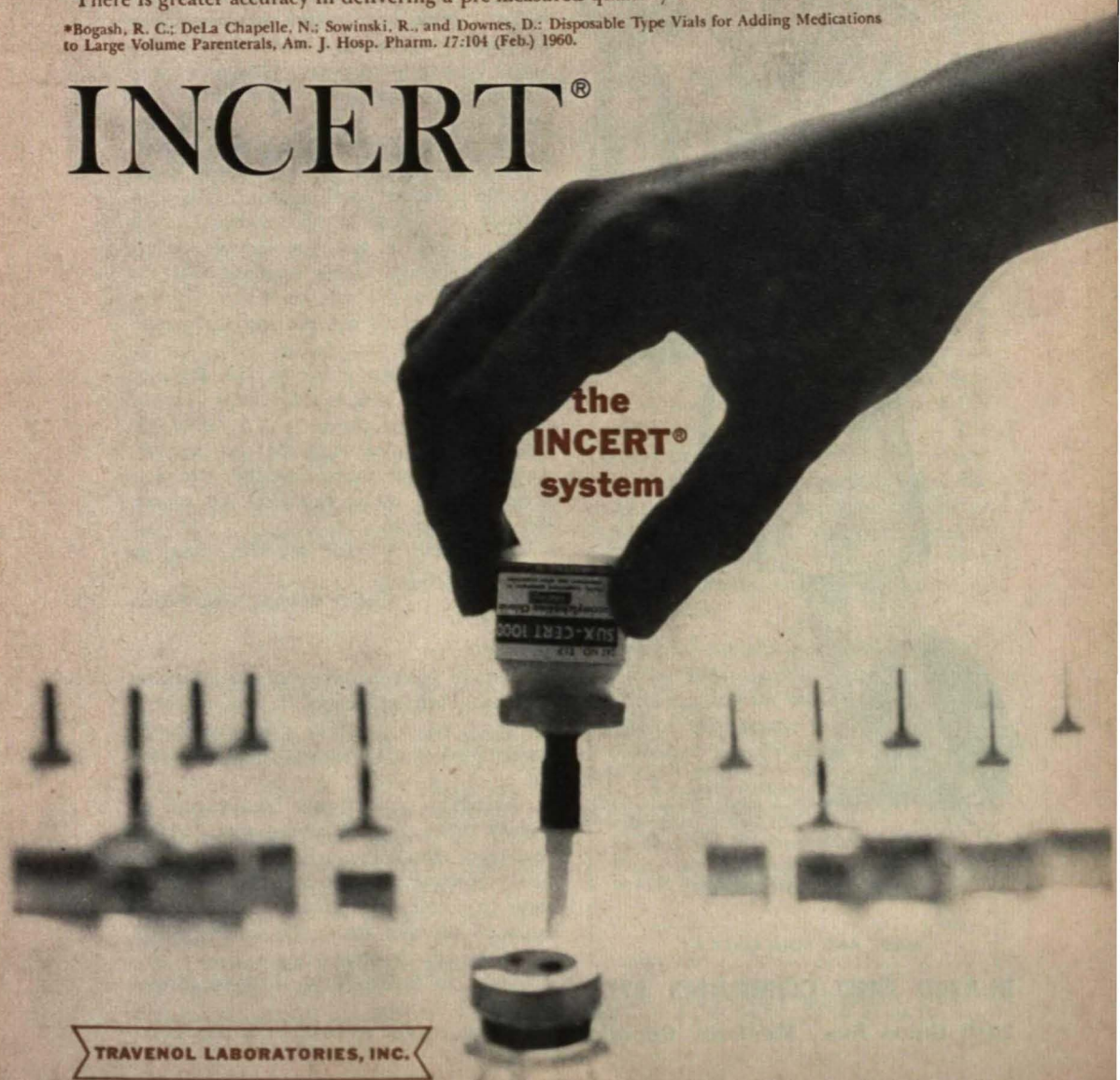
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*Bogash, R. C.; DeLa Chapelle, N.; Sowinski, R., and Downes, D.: Disposable Type Vials for Adding Medications to Large Volume Parenterals, Am. J. Hosp. Pharm. *17*:104 (Feb.) 1960.

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Random Comments

Dear Editor:

I have appreciated the *Journal* very much. It is hard even for the students to remain up-to-date. This continuing source of good solid material, with a changing emphasis every month, is useful, even if it only keeps us all aware of our ignorance!

As a student from a psychiatric hospital, I particularly appreciate your efforts in depicting the inter-relationship of psychiatric nursing and general nursing. I am also happy to see how much you encourage nurses, both student and graduate, to continually study their work and to attain a higher cultural level, which is so satisfying personally, and to set a standard of professional conduct in everyday relationships with individual patients which will benefit all concerned.

The October issue, dealing with aspects of real importance to the psychiatric nurse, I would commend to all nurses. I only wish I could give it to all the students in our school. There is still considerable feeling among students in this province that the *Journal* is for graduate nurses exclusively. Perhaps you could get the schools to push it. I get the distinct feeling that they are one of the main sources of the students' impression that it is not for them. This is reasonable if one considers the rather radical (at times) opinions that are set forward, which put courses as they are *now* presented in a rather bad light. Of course, this is *my* opinion.

To conclude, I would say only: keep up the good work!

PHILIP GOWER, Nova Scotia

Dear Editor:

I am a student nurse at the Moncton Hospital Training School. I wish to thank you very much for *The Canadian Nurse* Award — a year's subscription to the *Journal*.

Although it was always available to us student nurses, I must confess that I rarely read more than a few articles in each issue. After receiving my own copy I have read it quite thoroughly, and found it very interesting. I am sure that every student nurse would benefit from reading it, since this would be an excellent way to keep abreast of modern thinking.

KATHLEEN STEEVES, New Brunswick

Dear Editor:

For the first time since our alumnae was organized, honorary life membership has been conferred. The recipients were Mrs. Robert Darrach, Miss Christina Macleod and Miss Jessie Fenton.

At a recent meeting it was suggested that we ask our graduates, through *The Canadian Nurse,* to send their addresses to the Alumnae Association, Brandon General Hospital.

MRS. ARTHUR LEWIS, Ontario

Dear Editor:

A friend of mine, a research scientist, found the section on Scientific Creativity in the article "Psychiatry has Something to Say" (October) most interesting and informative. Indeed, he thinks that the *Journal* produces thoughtful, serious articles, the equal of any other professional journal.

EVELYN M. WHITE, Ontario

Dear Editor:

The W. K. Kellogg Foundation has issued a brochure entitled *The Planning and Operation of An Intensive Care Unit.* The brochure recounts the experience of Community Hospital of Battle Creek, Michigan in the planning and establishing of an intensive care unit.

In making this brochure available it is the Foundation's intention to assist hospitals generally in considering whether this concept of patient care could be advantageously applied in their particular situations.

The Foundation has a supply of brochures and will be glad to furnish reasonable quantities gratis upon request to our headquarters, 250 Champion Street, Battle Creek, Michigan.

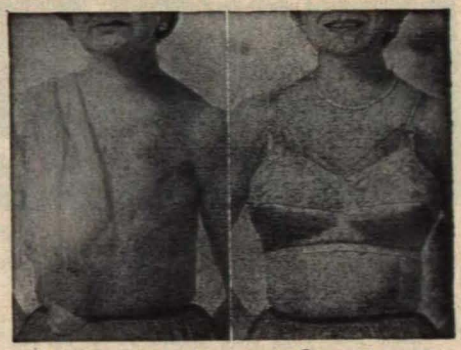
H. B. POWELL, Publications Director

The federal Department of Labor has made available a new booklet as part of its fair practices education program. The booklet entitled *Discrimination — Our Achilles Heel?* contains the text of a radio broadcast written by STANLEY G. GRIZZLE and delivered by him on the radio series "Canada at Work."

The booklet provides excellent reference material and good reading on the subject of what Canadians can do to fight bigotry and intolerance effectively. Copies may be obtained by writing to Mr. Bernard Wilson, Director, Industrial Relations Branch, Department of Labor, Ottawa.

—*Human Rights Review,* Vol. XVI, No. 3.

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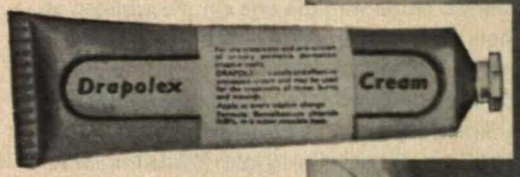
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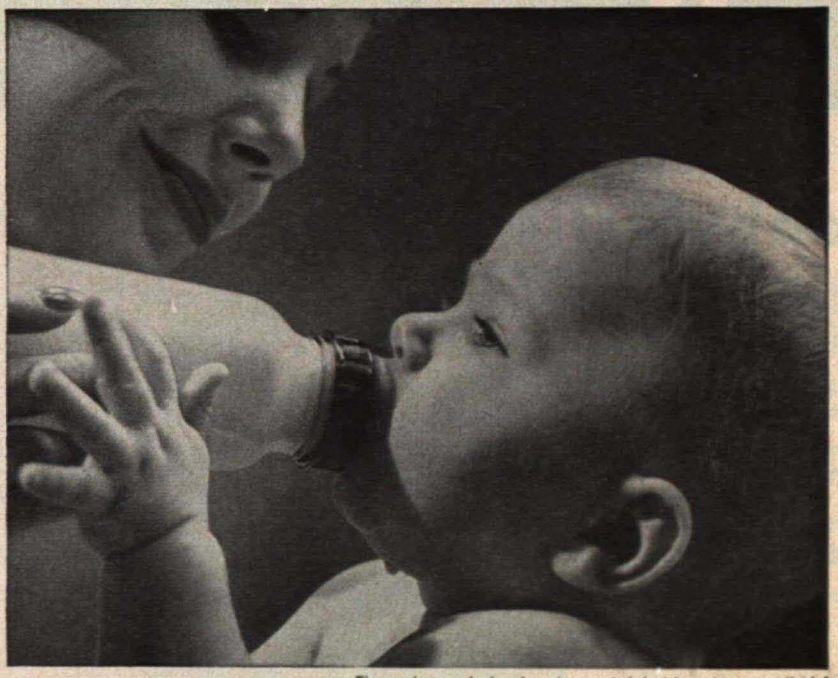




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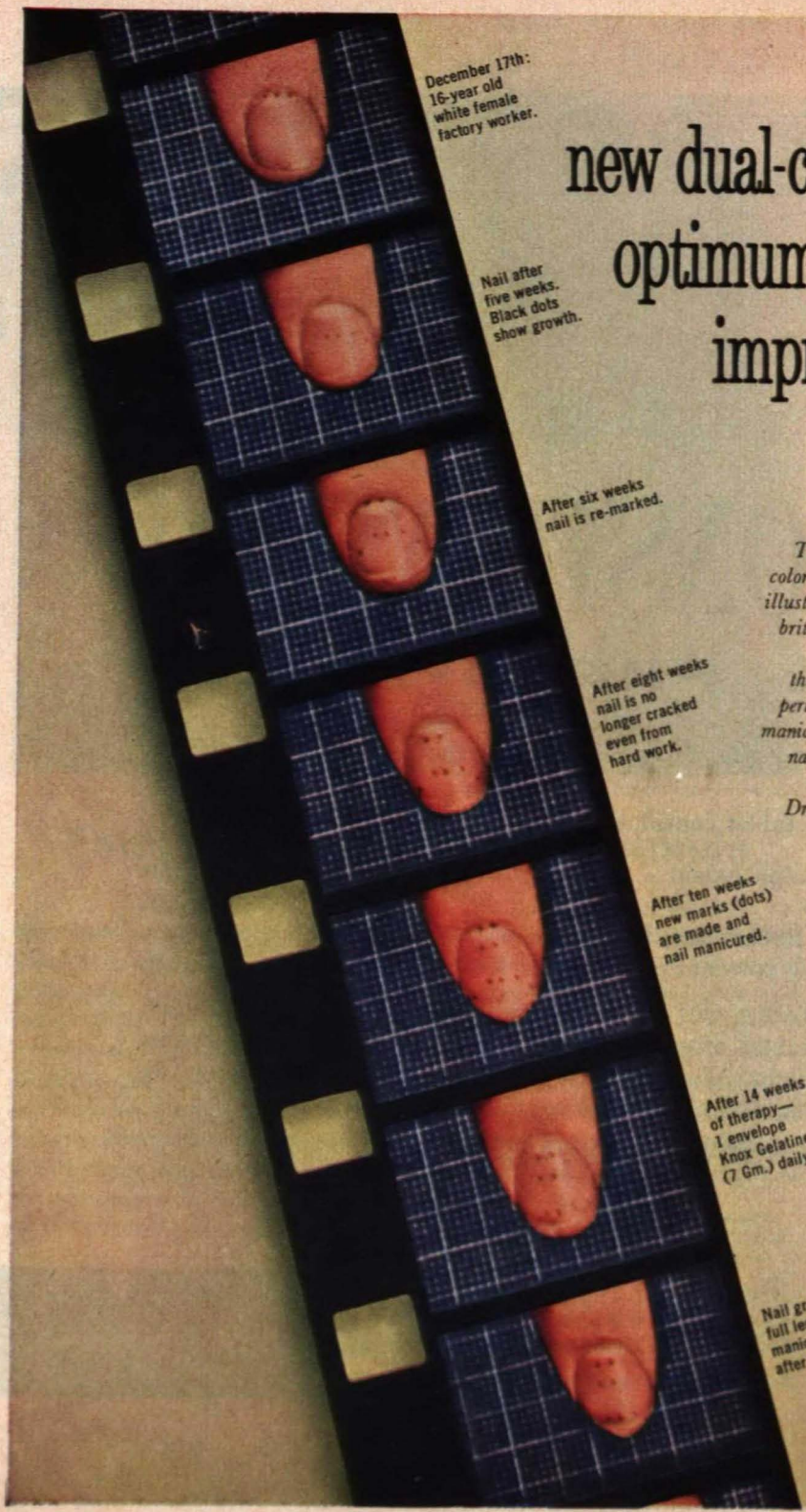
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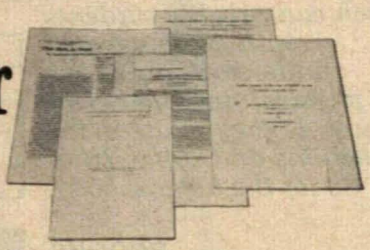
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study[1] establishes of Knox Gelatine for brittle fingernails



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☐ 1. Derzavis, J.L. and Mulinos, M.G.: Med. Ann. D.C. XXX:133, March, 1961.
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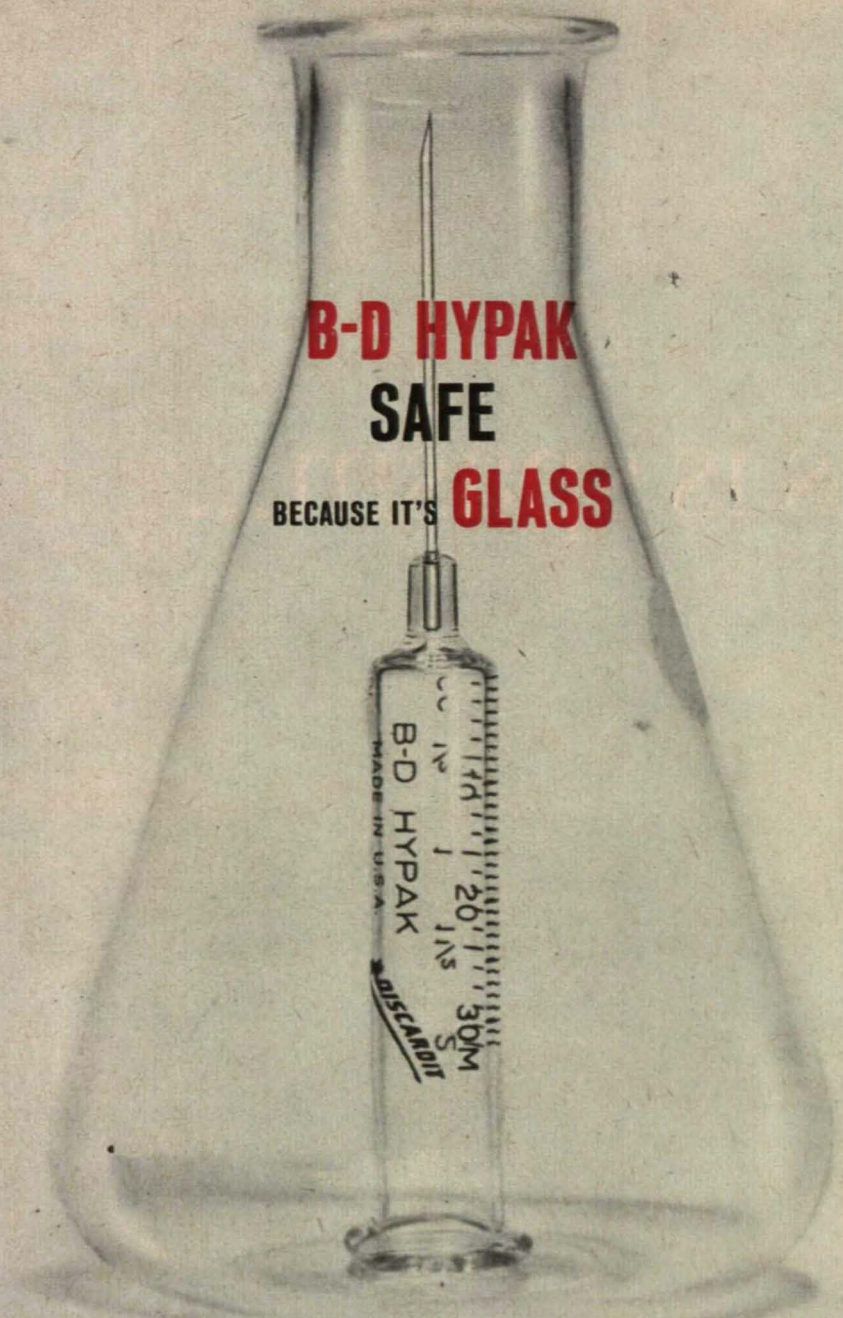
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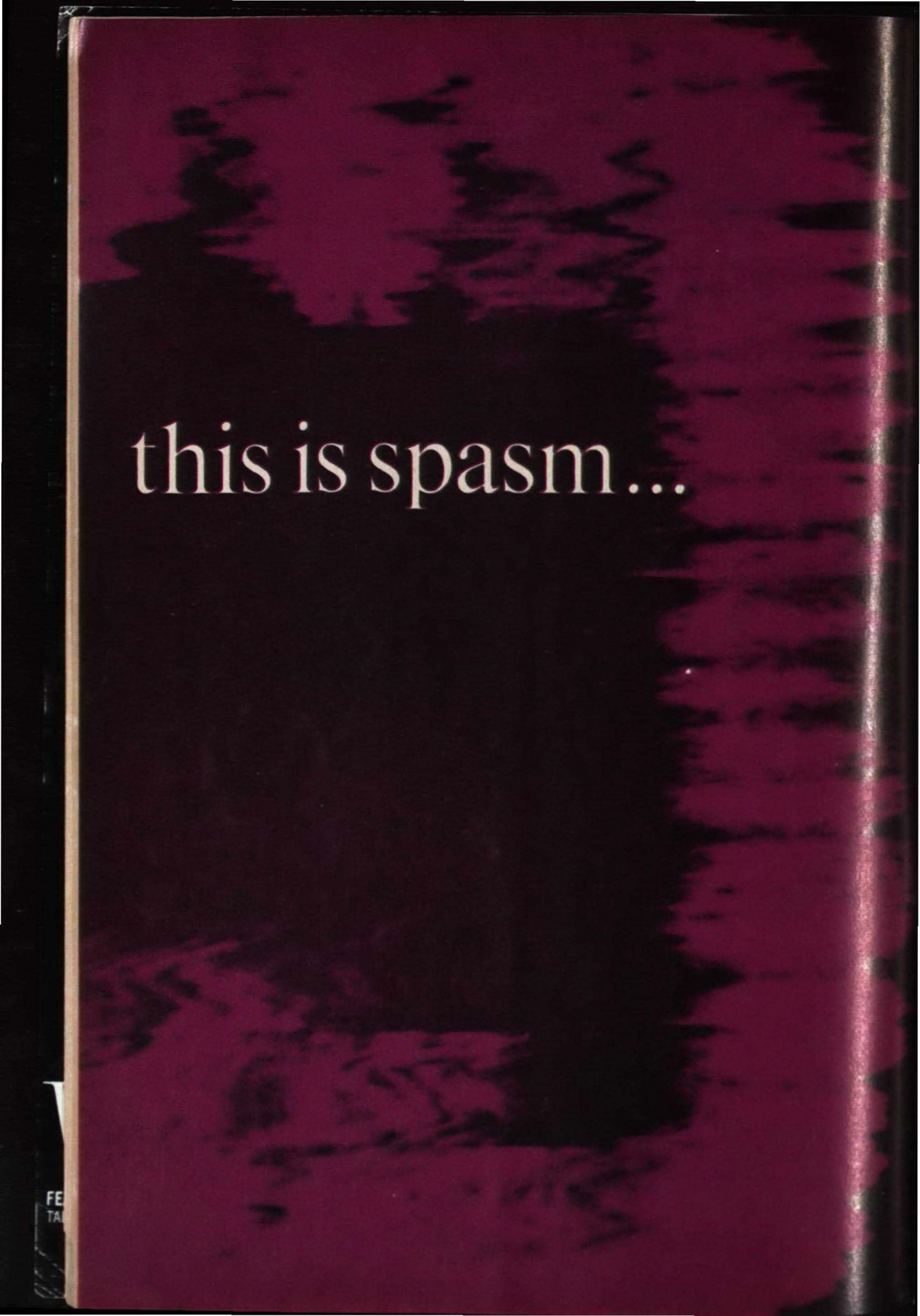
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VOLUME 58 NUMBER 1

MONTREAL, JANUARY 1962

Always Some Certain End Must be Kept in View

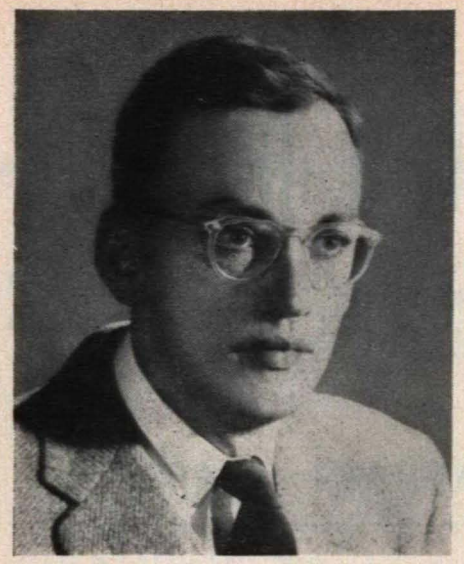
AMONG THE important objectives of any professional association is the maintenance and improvement of the standards of service rendered by its members. This objective is of special significance to the nursing profession in Canada today. The advances in medicine, together with rapid social and economic developments in our country, have resulted in pressure on nurses to assume additional responsibilities and to extend their services to more people than ever before.

With these considerations in mind, the members of the Canadian Nurses' Association, gathered at the 1960 Biennial meeting, were unanimous in their acceptance of the recommendations that arose out of the Pilot Project for Evaluation of Schools of Nursing. They charged the incoming Executive with responsibility for taking immediate steps to implement the first three. All these recommendations are designed to contribute to raising the standards of nursing service.

What has been accomplished in the past eighteen months with regard to these important matters?

Recognizing that the quality of nursing service provided is dependent to a large extent on the quality of education the practitioners receive, the Association's first commitment was to initiate a study of the whole field of nursing education. Miss Mussallem gave a good deal of time and thought to the development of plans for this project and presented several alternatives to the Executive for study and consideration. Various approaches were considered; among these were the use of Royal Commission techniques employing a single commissioner or a group of commissioners; and a survey under the direction of a competent researcher. The latter plan was considered the more feasible. A tour was made across the country to interview people suggested as project director. Following this, recommendations on those considered most suitable were made to a Selections Committee named by the Executive. After careful consideration, Dr. Kasper Naegele was invited to direct the study.

The Association is fortunate in securing a man of Dr. Naegele's calibre



KASPER NAEGELE

and qualifications for this important piece of work. The study is now in the planning phase, and Dr. Naegele is prepared to give full time to the project commencing this spring. His objective is to complete the study and prepare a draft of his report by December 1963.

The steps taken by the Executive to implement the school improvement program, the second recommendation of the Pilot Project, are familiar to many, as 156 schools of nursing are currently participating in this program. Miss Glenna Rowsell, formerly Associate Director of Nursing Education of the St. John's General Hospital, Newfoundland, joined the staff of the Canadian Nurses' Association in March 1961 to direct the program. Questionnaires, schedules and guides were prepared and distributed to the staff of schools wishing to participate in the project. Miss Rowsell has just completed a tour of the country, holding 19 regional conferences with members of the teaching staff of the participating schools, and interpreting the program to administrative personnel in hospitals and to key people in the health field. The staff members are now completing a self-evaluation guide, designed to assist instructors in critically examining their educational programs. These completed self-evaluation guides will be reviewed this spring prior to planning for regional workshops in the fall. The focus of these workshops will be on aspects of the educational programs which require study and improvement.

At the Biennial meeting in Halifax, it was recommended that the school improvement program accent those values in education *that can be transferred to any new system* that may be developed in the future. While striving to improve the quality of education within the present system, we must keep in mind that the purpose of the first recommendation, a study of the whole field of nursing education, is to enquire into the present pattern of education for nurses in Canada and, in the light of changing conditions, consider modifications that may be necessary or desirable. We trust the interest in the school improvement program will contribute to a readiness to examine the current situation objectively and will be of assistance in preparing nurses to give reasoned consideration to the findings of this study.

The third recommendation of the Pilot Project, a study of the quality of nursing service in areas in which students receive their clinical experience, is in the hands of Miss Lillian Campion, well-known to many as an experienced member of the staff of the Association and one with depth and breadth of knowledge in both nursing service and nursing education. The Executive was gratified that Miss Campion consented to direct this important piece of research in which so little has been done heretofore. Criteria for the evaluation of nursing service are currently being developed. This is a task that requires much study and thoughtful consideration. We look forward with interest and anticipation to a progress report concerning this project at the next Biennial meeting in June.

The Executive of the Canadian Nurses' Association consists of some 36 members, about two-thirds voting members elected to office, and one third non-voting members, among whom are the provincial secretaries, the national executive director and the editor of our *Journal*. The Executive is charged with responsibility for leadership in the work of the Association during each biennium. The term of office of voting members is usually

from two to four years. Rarely does a member serve eight years or more. Whatever the length of service, the contribution of voting members is but a brief one in the life of the Association. The work continues from biennium to biennium under the capable direction of full-time staff, and with the active interest and participation of the members. The contribution the members can make to the work of the Association has no limits, when one considers that there are over 60,000 members in it. In each province, the nurses' association selects voting delegates from among its members. These delegates are responsible for decision-making at each biennial meeting. Members have the opportunity to discuss the work of the Association firsthand with their associates and with colleagues and interested citizens in their communities. Members who work in the various fields of nursing represent the profession to the public and accept final responsibility for the standard of service the people receive.

Always some certain end must be kept in view! During this biennium we are particularly concerned with the *quality* of our service. The success of the Canadian Nurses' Association in the work it has undertaken toward this end rests with the members. We trust that as many members as possible will attend the Biennial meeting in Vancouver, June 24 to 29, to share in the discussion of the business of the Association, and to give consideration to the reports that will be presented concerning these three important projects.

HELEN M. CARPENTER, M.P.H.
President
Canadian Nurses' Association

THE PATIENT'S RIGHT TO KNOW THE TRUTH

A. MILLER, M.D.

The treatment of this provocative and complex subject would vary considerably from one individual to another, each approach being influenced by such things as life experience, educational background, vocation and personality characteristics. This is so because it deals with an issue with ramifications that take in the fields of biology, sociology, ethics, philosophy and religion.

I WILL DEAL with this topic by first examining it from a descriptive point of view; next, I will look at a cross section of opinions from professional and lay individuals, then conclude with a scientific examination of the problem.

At the outset it should be understood that this topic does not refer specifically to any medical problem. It is concerned with an aspect of human experience — one in which pain, suffering, loss and death are involved and the manner in which human beings respond to this circumstance. The quality of the reactions seen represents the way in which the problem is experienced and the individual techniques that are used for coping with it. Central to the reaction patterns are the kinds of values and beliefs which the individual applies in his appreciation and response to the problem. In many ways, this represents the beliefs and values of the culture in which he lives. It is clear that this is not an issue which is limited by age, race, religion, or physical characteristics. It involves everyone. It is for this reason that the problem becomes more complex, with all shades of interpretations, and the inevitable differences which range from one pole to another.

Man's habitual attempt to establish a rational approch to problems applies equally to the topic. There has always

been a fond wish to find a method or concept capable of satisfying and solving the circumstance of threat and danger. However, the very nature of this problem has so far prevented agreement on any universally acceptable approach. This is as true for the professional groups — doctors and clergymen, who have a much closer investment in this problem, mainly because of the frequency with which they come in contact with it — as for the layman.

Areas of Problem

Before proceeding to an examination of opinions and the scientific data that have been gathered, let us be quite clear about the issues. We are concerned with a situation that arises when an individual is caught up in circumstances that threaten his health and security. The problem for us, who are in the position of knowing the facts, is whether or not to reveal the truth.

Let us take some specific examples where this kind of circumstance develops and when someone, usually a doctor, is required to make a decision as to what he tells the patient and what he does not:

1. How does one tell a mother that her newborn child has an irremediable defect or that the child has not survived?
2. How does one tell parents that their child has a fatal disease, such as leukemia, and also what do you say to the child?
3. How do you tell an individual that he carries the gene of a serious, crippling and ultimately fatal disease, such as Huntington's Chorea?
4. How do you tell a person that he has a condition which marks him for a life of invalidism, pain and incapacity, e.g., multiple sclerosis?
5. How do you tell parents that their child is suffering from an unalterable mental disorder?
6. What do you tell the patient who is found to be suffering from a malignant disease?
7. What do you tell the patient who you know is engaged in a struggle with a fatal and terminal disease?

These are examples of the many questions one may pose. It is clear that there is no easy answer — either for the patient, the relatives, or for those trying to find the best way to help.

Cross Section of Opinions

Interestingly enough, most of the literature on this subject directs its attenion to two specific problems. But the points raised can be applied to a wide range of similar problems and therefore satisfy our examination of the subject.

1. What approach can one take when it has been established that a patient has cancer?

and

2. What can one say to a patient who is suffering from a terminal disease?

Physicians

It is apparent immediately that there is little unanimity regarding what constitutes a proper approach. Among physicians, there is considerable difference of opinion about the problem. A study carried out by one group revealed that 30 per cent of the physicians, who were asked to reply to a carefully prepared questionnaire, indicated that they always or usually told their patients the facts of their medical problems. On the other hand, 70 per cent of those answering usually did not or never told their patients. Those doctors who felt that telling the truth was necessary and important indicated that employing subterfuge and avoiding the truth was contrary to the doctor's position and was really a reflection of a mistaken sense of kindness and compassion. They further indicated that giving information allowed the patient to meet his problem more realistically, enabled him to put his affairs in order, gave the opportunity for confidences to be exchanged with relatives and business associates, and made it possible for him to be prepared for the difficulties that were ahead.

The doctors who disagreed with this approach argued that telling the patient bluntly about his condition did not alter the situation for the patient, in the first place, and that it also created unnecessary anguish and pain. They further indicated that the reaction to such information could be serious, possibly precipitating a severe emotional disturbance, perhaps even a suicidal act. One further point

made by a clinician who argued against giving the information was that medical science was not exact, that occasionally the facts of the case were misjudged or that the findings were in error. If the clinical evaluation was not accurate an unnecessary degree of pain and emotional upset for the patient and his family would be created.

In general, the opinions came down to certain basic issues. For those who felt that it was important to conceal the diagnosis, the points were that:

1. Exact knowledge of the illness could precipitate too great an emotional burden for the patient who could respond with panic, depression and, possibly, a loss of capacity for productive living during the rest of his life;

2. most patients really do not want to know the truth about their illness, although this was generally not stated specifically. This was regarded as an important patient need and something that the doctor should recognize and accept.

The points in disagreement with this approach were these:

1. It really is impossible to deceive the patient about his illness. His own awareness of the truth of his condition was transmitted frequently by many subtle signals in his everyday relationships.

2. Inasmuch as most patients suspect their diagnosis and become aware, at some point, of their medical problem, attempts to conceal it with optimistic statements breed distrust, resentment and emotional isolation. As pointed out, the patient needs to feel trust in his doctor and a sense of closeness to his relatives and friends, and it was considered that this realization helps him to bear his illness and to meet important personal needs at a time of crisis. If he were deprived of this with unrealistic and unconvincing statements, it might lead to a destructive situation.

3. There are patients who have known their diagnosis and have had the strength to continue productive living. It has been demonstrated, frequently, that there are inner strengths in people which can be mobilized at a time of crisis.

4. By bringing the problem out into the open, it enables the medical adviser and others to help the patient with the difficult emotional reactions which arise. This is considered to be positive and helpful.

Clergy

The rabbi, priest and minister are, of course, frequently involved when the patient is facing these difficult problems. What is the consensus of the clergymen? To the best of my information, the majority of clergymen consider that the truth should be given to the patient. They emphasize that the important thing is the way in which the truth is presented, that is, the kind of words that are used and the support that is given to the patient. The emphasis, again, is on softening the impact of unpleasant news, attempting to reduce the feelings of despair and keeping the prospect of hope and faith alive. At the same time, however, it is noted that facing realities and bringing them to the forefront allows the patient to deal with practical issues, frequently to avoid hardships for the person and his family. Eventually this helps the patient to achieve a state of peace and acceptance. Most important, it allows the patient to come to grips with his faith and his religious beliefs in such a way as to give him a sense of comfort and peace.

The Average Person

What does the average person feel about this problem? It is difficult to arrive at an accurate summation of opinion but a fairly strong impression has emerged. It is this. Any reticence on the part of the doctor to discuss with a patient the details of his case, particularly when there is a question of serious illness such as malignancy, constitutes a gross under-estimation of human intelligence and courage. Indeed, many people believe that the doctor's decision to conceal information is a rejection of man's ability to handle difficult problems. It is argued that it is important for a man to have the opportunity to decide what to do about the circumstance in which he finds himself and to have the opportunity to prepare himself for the problems in his life, to look after the arrangements which are necessary and to have the opportunity to benefit from spiritual help. Nothing should interfere with man's need to achieve a sense of dig-

nity. Every effort must be made to maintain it.

Psychosocial Aspects

Looking at the psychological and social aspects of this problem there are several points that can be made.

It has been stated that the values of our culture tend to reduce man's capacity to deal with inevitable facts of infirmity or death. It seems clear that the dependence and inadequacy inherent in any illness are defined culturally and experienced individually as bad and to be feared. Doctor, patient and family members are all subject to these emotional forces and they consciously strive to shield themselves from meeting human mortality and vulnerability. Therefore, the patient with a serious illness, who chooses to deny the threat of his condition, seems to come to the conclusion within a milieu which encourages evasion. In many subtle ways we, who are well, discourage the patient from being faced with the frightening truth. This reflects the attitude of our modern culture. The advance of medical science has led man to expect a longer life, relative freedom from physical pain and, possibly, the eventual banishment of disease.

This development has played its part in creating attitudes and beliefs toward health and disease that have influenced the kind of approaches and reactions that one sees so frequently in the circumstances of a threat to one's survival. This, then, may be seen as one of the factors that has shaped and influenced the thinking of people when confronted with the difficult problem of survival. What happens in the actual clinical situation? What can we learn about the reactions of people when confronted with difficult medical conditions and when there is a threat of disability, pain and possibly death?

These reactions have been observed many times. The observations have allowed a cataloguing of the reactions that occur most frequently. This information has been used to determine what kind of approach is best in a given situation. It is quite clear that the physical condition which the person has is merely the point of reference or the basis for considering the problem. In every instance, it is the emotional reaction and the personality in whom the emotional reactions develop, that are the real issues. The question whether the patient is told or not told of his condition is decided on the basis of what the patient's needs are. Some people have been able to look after themselves amazingly well under the most adverse circumstances, whereas others are psychologically bankrupt and literally fall apart in the face of new, threatening and frightening situations. This latter group, however, is relatively small and in fact proves that people are not as brittle as some may think.

There are certain guide-posts that one can use to prognosticate the type of reaction that a person might exhibit when confronted with unpleasant news about his health. These reactions, with varying degrees of intensity and duration, are seen fairly regularly. First there is an initial phase of shock with acute feelings of fear and depression; this is usually of short duration and sometimes is not seen at all because the patient has already suspected the truth. This initial phase is accompanied by great anxiety and feelings of unreality associated with an inner feeling of "This isn't me! It really can't be happening." This phase is often dreaded by the physician and the family, so in order to avoid it the diagnosis may be withheld. It should be emphasized that this phase is uncomfortable not only for the patient and the family but also for the attending physician. Fortunately, it usually passes rapidly into the second phase which contains early measures to deal with the stress.

The second phase is marked by the use of common and protective psychological mechanisms the most common one being denial. It is the most commonly used defence employed by the personality to protect himself from overwhelming, catastrophic anxiety. We should realize the importance of respecting it. Since over-determined defences occur at a time of intense threat, to remove them forcibly might precipitate a severe panic or depressive reaction. Strong or persistent denials are rare and when they do occur may have to be accepted as such. It rarely happens that this reaction is irreversible. Usually, it lasts for a

relatively short time and is brushed aside by the issues of reality and the individual's capacity to test reality. During this second phase the patient gradually, through a process of mourning, leaves behind the image of himself that he recognized before his illness. Usually, there is an almost agonizing reappraisal of self with a final acceptance and integration of the disease with its full implications. This, then, leads to the third phase, which is really an extension and a completion of the second.

The patient gradually forms a new picture of himself with altered prospectives and goals. This is accompanied by a change in behavior. The patient has achieved an effective adaptation of the circumstances in which he has found himself. The question is: how can one determine the quality and the kind of adaptation that the person will have to stress? This can be determined on the basis of knowledge of the patient and his capacity to deal with stress in the past. Therefore, one would want to know something about the patient's adjustment to work, to his relationship with people, the quality of his domestic life and the quality, generally, of his daily living.

If there are many positive elements and it is clear that the patient is able to handle stresses relatively well, there should be no hesitation in telling him the truth. Of course, it is important to emphasize that the approach taken is of great significance. This sometimes plays the most crucial part in the management of the problem. Even though the truth may be presented in the fashion that is easier for the patient to tolerate, this does not interfere with the ethical aspects of the doctor-patient relationship, the most important point being that any approach which infuses the idea of hope makes the burden more tolerable for the patient. Reassurance of the individual by promising a degree of comfort and offering positive aspects can often help in great measure. It is argued that withholding the diagnosis is imperative in order to prevent severe emotional breakdown and perhaps suicide but, again, this is not borne out by the facts.

Presentation of Information

How then can we assess this problem? What can we say to the question of "Does the patient have the right to know the truth?" It obviously depends on a multitude of factors and it cannot be answered by a clear "yes" or "no." It is necessary to take the total situation into consideration — that is, the medical problem, its implications for the individual and his associates, the age of the patient, his personality resources and his needs. One has to accept the fact that there will be a stormy period in practically every situation, but that in most instances adequate adjustment will take place and in the final analysis the individual will work through his problem, establish a better quality of adaptation and deal with realities of living and the opportunity to meet his needs — whether of an emotional or spiritual kind — more effectively. These provide the real basis for the kind of approach that one must take.

There are certain things that we have learned about how to approach this very difficult problem. It means, in most instances, that one has to assess the total situation before presenting the patient and his relatives with the facts. But, there is one point that requires re-emphasis — the method of presenting the problem, the words that are used, the quality of the relationship with the patient at such a time is very important. The presentation of information without infusing the element of hope could lead to a serious and unfortunate reaction. Indeed, it is the element of hope which probably provides the greatest spark to man's capacity for adaptation. It illuminates and infuses the individual with a feeling of being worthwhile and important within the framework of positive aspects of his existence.

The business of education in respect of knowledge is not to perfect the learner in all or any one of the sciences, but to give his mind that freedom, that disposition, and those habits that may enable him to attain any part of knowledge he shall apply himself to, or stand in need of, in the future course of his life. — JOHN LOCKE

How Our Behavior Affects Patient Care

LOIS N. KNOWLES, B.S., M.A.

The problems that the patient with cancer of the lung presents to the nurse are many and varied.

THE PATIENT who has had chest surgery presents many problems to the nurse. These can be divided into two categories: 1. Those related to activities involved in carrying out the medical regimen ordered by the physician; 2. those concerned with the activities involved in identifying nursing problems and in carrying out nursing functions in the light of how the patient visualizes himself as a person who has a disease.

The many activities arising from the physician's orders, which the patient and the nurse experience together in preparations for surgery and immediately thereafter, serve to develop a positive interpersonal relationship. The nurse's functions in the preoperative stage which involve such activities as skin preparation, preoperative drugs, and enemas, or in the postoperative phase, such as the care of chest suction apparatus, recording of vital signs, administration of intravenous fluids, analgesics, and antibiotics, are necessary, vital and important. The majority of these functions are performed by the nurse in response to orders from the doctor. It can be assumed that nurses possess varying degrees of expertness in performance according to their background and experience. They may need demonstrations of the use of special equipment, particularly chest suction apparatus, before assuming responsability for the care of these patients. Before and after surgery, the patient experiences considerable stress as the result of physical examinations, diagnostic tests, and treatments. These activities often produce pain and anxiety.

The second phase of the nursing functions is closely related to the first but is more intangible, less clearly identified, and requires different skills. The results are difficult to evaluate. These functions involve the use of the nurse as a therapeutic catalyst. Her role as a comforter consists largely of the activities which she performs that are not in response to the doctor's orders. As a part of the nursing process the nurse must develop sensitivity to the patient's reactions to his illness. He may display his feelings verbally or by nonverbal actions. What he does *not* do is often as important as what he does. From her observations, the nurse can write a description or nursing history of the patient from which she can identify the problems which she finds to be important in his care. Through evaluation of her nursing activities she can learn which efforts produce comfort and which do not. In this way she will be able to visualize nursing as an on-going process.

Surgery for cancer of the lung is a serious matter since the person who has such a diagnosis is often one who is soon to die. Statistics indicate that by the time the patient comes to the hospital, the tumor is frequently inoperable. It is inevitable that there will be anxiety and fear. These feelings are met by the nurse in various ways according to the extent to which she is aware of and can cope with her *own* feelings about them. There are enough stories in magazines and newspapers for anyone to be very much alarmed if, following a routine chest X-ray, he is advised to go to the hospital for more studies. His reluctance and delay may be due to fear. Forced cheerfulness may indicate that he has denied to himself any possible chance that he might have a malignant lesion.

Nurses have commented that these patients rarely talk about their illness. There is a tendency for the nurse to lavish attention on them in order to "try to cheer them up." The "cheering up" can be interpreted in various ways. The role of the professional person is surely not to overlook the patient's problems and talk about a current movie or the roses by his bed. Rather, it is to help the patient express how he feels so that he can cope with his

problem more easily. By talking with a nurse he can experience relief and comfort because someone is sharing his troubles with him.

It is becoming more acceptable for nurses to sit down beside a patient and talk with him about his feelings. Experience shows that there are two main facets of concern: The feeling of guilt as expressed by "Why did I smoke all those cigarettes?" and fear of the possibility of death. Either of these can make a patient tense and anxious which challenges the nurse to give of her best in providing care. The patient's family also suffer from extreme feelings of guilt. This was evidenced by a mother who said over and over during the five hours that we waited outside the operating room, "What did I do that was wrong?"

Nurses who care for a patient with a malignancy may experience many of the same feelings that he has. They may feel guilty that they cannot help their patients to get well. If it is obvious that he will not recover, the nurse may react in several ways. She may go to the patient's room only to give him treatments or medications or stay away because "she can't do anything." She may avoid the patient's family; be gruff or abrupt with them when it is the disease that is really upsetting her; or she may cry because she feels completely frustrated. She may avoid establishing a close relationship so that she won't get hurt; announce that there *must* be a drug that will help him; oversell X-ray therapy; deny the patient's illness and, in particular, try to cheer him up if he says that he is going to die. She may empathize with the doctor in that they are facing a similar problem and then be angry with him because he cannot make the patient well. She may complain about the doctor not visiting and feel an extreme loneliness in helping the patient through the last stages of his illness.

What can the nurse do to help herself cope with both her own and the patient's feelings? Personal experience has proven the helpfulness of the following: Live one day at a time and try to make the most of it by giving physical and emotional comfort to the patient. Sometimes, it is living *one hour* at a time, rather than even a whole day. *Now* is the only time available and we must make the most of it.

It is important for the nurse to be flexible enough to let the patient move within his limits and to enjoy his advances with him. She has to decide the proper moment to take total responsibility for his care when, in her clinical judgment, she thinks that the patient is ready for this. She can convey to him that she is interested in him as a person. She can tell the patient hopeful truths: That the medication will take effect soon; that she will be with him when he is uncomfortable; that she has confidence in the doctor and in the treatments whether it be X-ray, surgery or any other. Let the patient know that she knows it is hard for him to go through the illness, but that it is all right for him to react to it in his own way—to cry, to turn on his light, etc. If he speaks of dying, she gives him her attention. If it seems appropriate, the nurse can share her own thoughts about dying with him. It is sometimes difficult to allow a patient to say that he does not think that he will get well, but he has a right to do so. The Bill of Rights for Patients includes the right for him to express himself and to count on the nurse to listen to him.

In an environment where the feelings of the patient are heard and accepted by the nurse, she needs to have someone who accepts *her* feelings. The team leader and the supervisor are the logical persons to support the nurse emotionally. A kind word about the care of a patient helps to bolster her morale tremendously. A pat on the shoulder may do more than words to let the nurse know that they understand how she feels. The team conference is an excellent place for her to ventilate her feelings and to gain group support. Then it becomes a group experience and not just a burden one nurse is bearing alone.

The nurse plays an important role in supporting the patient's family. The decision to send a terminal patient home may depend upon how much emotionel support the family can give. The public health nurse can be very helpful by offering encouragement and advice. When the burden becomes too great for the family member or a friend, the visiting nurses fill a real

need as they give the patient care several times a week.

The following description of the reactions of four nurses to the terminal cancer patient illustrates how their behavior affects the care that the patients receive.

Nurse No. 1 is a cheerful Pollyanna who has a new joke every day. When the patient complains she may ask him why he is doing so, and brushes aside his complaints with facetious remarks. She sees to it that the conversation does not get below the superficial social level. She knows the patient's hobbies and the patient learns about what she does for recreation. She can be depended upon to advise the patient to keep his chin up. She takes it upon herself to be the ward's morale booster. No one has ever seen her depressed nor has anyone ever known what she was really thinking. She always initiates conversation so that she can be sure that it is what she wants to talk about. In this way the patient does not have an opportunity to tell her what his hopes and fears are. She protects herself with a coat of armor so that the patient does not catch her unaware and say that he is afraid.

Nurse No. 2 exemplifies tender loving care. She is docile, unassuming and lets the patient know that he is absolutely the sickest patient that she has ever seen. She busies herself all day long lavishing such attention on him that he begins to wonder if he really is going to die soon. Why else would she give him more attention that anyone else in the ward? He decides not to ask for pills for his pain because she has done so much for him already that he simply cannot impose on her any more. However, during visiting hours when his family are present he may request the nurse to do a few small favors for him in order to show his family that this is the kind of care he expects *them* to perform when he gets home. It is often a relief to the patient when Nurse No. 2 leaves. Her comstant hovering over him to make him comfortable begins to make him increasingly uncomfortable. She does not let him do anything for himself except breathe and she would do that for him if she could. Her continued *helpfulness* increases his *helplessness*. This nurse may cry when the patient cries. He may feel guilty for giving so much trouble and unhappiness.

Nurse No. 3 is the woman who, prior to the surgery, gained a deep understanding of the patient, his hopes, his fears. The patient counts on this trusting relationship to carry him through his illness. But he discovers that this is not possible postoperatively when the diagnosis of inoperable cancer of the lung has been made. The nurse finds that it is difficult for her to meet him face to face. She avoids entering his room except on request or in order to carry out a doctor's order. She gives the impression that she is angry with the patient when actually she is angry because of the disease. She feels that she has been betrayed by an insidious enemy that she cannot fight openly so she "fights the patient." If a patient says that he is ill because he smoked so many cigarettes a day, she reinforces his guilt by telling him he should not have done this. She punishes him for having the disease since she wonders how she is going to cope with the situation now that there is no hope in sight. In some cases the nurse absents herself from work because her feeling of guilt is great. If the preoperative nurse-patient relationship has been especially strong, she avoids looking at him when she does things for him. She "keeps her distance" emotionally in order to discourage questions.

Nurse No. 4 focuses her attention on the *person* who has the illness and what it means to him. She uses every means possible to make the patient comfortable, mentally and physically, and she keeps him interested in common, everyday life experiences. Problems that are presented to her by other nurses or by the patient challenge her to find possible solutions. She lets the patient know that she cares about how he feels and what he thinks; that she realizes what a catastrophe the illness appears to him. One thing she and the patient are certain of is that she will be with him to give him understanding care as long as he needs her. She does not dwell on what is going to happen two months from now. She helps the patient to live, enjoy and feel as useful as he can during the present. She listens to his fear that the operation was not soon enough; that X-ray and nitrogen mustard therapy had to come too late. She does not give him false hope but what she has to say encourages him to trust her and convinces him that she is not selling him a "bill of goods." She does not refer all problems to the doctor. She

copes with them as they come along and knows that the doctor has confidence in her judgment as to what she can manage alone. She seeks help from other nurses and the doctors when she has too much to manage, either in the area of her own emotional depression or the patient's signs and symptoms. She gives the patient analgesics as needed to relieve pain and does not save them for a day that may never come. When death comes she can say to herself that she has helped a person to die comfortably, physically and mentally, and she can feel sure that she has done her best.

The problems that the patient with cancer of the lung presents to the nurse are many and varied. An attempt has been made to indicate some of the ways in which the nurse responds to them in order to help us realize how our behavior affects patient care. Nurses have many feelings about the patient in terminal illness. If the nurse realizes that it is acceptable and natural to have such feelings she is more likely to express them and gain support for her tasks. To be ill with a terminal disease is a lonely experience for the patient. If the nurse feels emotionally secure herself she can help the patient to be less lonely in experiencing the last developmental task, that of dying. If the nurse cannot assume the responsibility for being with the terminally ill patient, who will? Even his family may not be able to stay with him at this critical time.

In the Good Old Days

(*The Canadian Nurse* — JANUARY, 1922)

Definition of a pupil nurse: One who has entered a training school for the purpose of acquiring a knowledge of the moral, practical and scientific care of the sick.

She shall bring, as her contribution to this training: youth, health, enthusiasm, education, refinement, sympathy, a good reasoning power, and above all, a conscience.

* * *

Before the war (World War I) it was thought that the neuropathic tendency was much stronger in women than in men. Conscription showed that a large percentage of men were liable to neurosis, hysteria, and neurasthenia, provided the strain was sufficiently severe.

The Public Health Section of the Canadian National Association of Trained Nurses has been asked to consider the question of standards for the public health nursing courses that are being developed in Canada. Dalhousie University, Halifax, was the first to establish such a course in February, 1920. The University of British Columbia added public health nursing to its former curriculum in November, 1920. In January, 1921 the University of Alberta started the same work. The University of Toronto, McGill University and Western University, London all established their departments at the beginning of the academic year 1920-21. McGill also has a course for nurse teachers.

Coming!

IN FEBRUARY 1962

Guest Editor — Mary L. Richmond, Chairman Committee on Nursing Service, C.N.A.

Church, Gilchrist, Woodworth } Evaluation of Nursing Service Personnel

Hayter —So You Need a Consultant

Balcom and Palmer —Nurses' Responsibility in Cross-infection

plus additional material

STOKE-ADAMS SYNDROME

G. A. KLASSEN, M.D.

Comprehensive knowledge of this condition and its treatment are essential for the nurse, since her prompt action can be life-saving.

Etiology

STOKES-ADAMS syndrome is characterized by a 5-10 second or greater period of cardiac asystole during which no blood is pumped from the heart and anoxia of the brain results. Clinically, the patient has an attack of fainting. If it is prolonged, a generalized convulsion may occur. Usually the patient has no previous warning. He becomes pale at the onset, breathes deeply, stops breathing, becomes cyanotic, and may have a seizure. The attack usually ends spontaneously so that the patient has only a short lapse of consciousness although in extreme cases he may die. On recovery his face tends to flush and he may complain of dizziness. If a seizure has occurred, the patient will be confused for a short period of time. In almost all instances he will be frightened and anxious. It is possible to distinguish between such attacks and those of epileptic origin by the absence of pulse.

This condition was recognized by Robert Adams in 1827, and described in detail by William Stokes in 1846, hence its name, Stokes-Adams syndrome or disease. The abnormality lies in the conducting system of the heart. In the normal heart the beat originates in the sino-atrial node, a specialized piece of heart muscle located in the wall of the right atrium. The impulse spreads through the atrial muscle, causing contraction to the atrioventricular node between the two ventricles. The purpose of the latter structure is to delay the impulse long enough so that the atria can empty their contents into the ventricles before they start to contract. The atrio-ventricular node then passes the impulse on to the Purkinje network of the ventricule which transmits the impulse to contract to all parts of the ventricular muscle.

In cases of Stokes-Adams syndrome, the failure in function may occur at two sites. First, the sino-atrial node may fail to generate an impulse. This is uncommon. The usual cause of the condition is failure of the atrio-ventricular node to pass the impulse to the ventricles. Atrial contracture continues but the ventricles do not receive an impulse to contract and no blood is pumped.

In general, both of these nodes can be influenced by the nervous system. The vagus nerve has branches that slow the action of the sino-atrial node and inhibit the impulse at the atrio-ventricular node. This can be demonstrated by pressing on the carotid sinus and noting the slowing of the pulse in normal individuals. In certain people this response is exaggerated so that such pressure stops the heart and a Stokes-Adams attack occurs. The ventricle will usually start beating of its own accord even if no impulse arrives because the lack of oxygen causes irritability. A slow regular ventricular beat is established. This is called *ventricular escapement.*

Occasionally, abnormalities of the conducting system occur in families so that various members of the same family may have Stokes-Adams attacks. The commonest cause of failure of the system is arteriosclerotic involvement of the coronary arteries that supply these specialized nodes. A large number of cases have no detectable cause. The syndrome may have its onset at any age and in either sex but usually it occurs in older men. Its course is quite variable. The patient tends to get better and the syndrome may disappear. However, many patients may have repeated attacks for years. One attack usually is followed by several more. Attacks may be said to occur in groups with periods of normality between.

The diagnosis is made by the history of an attack and the detection of a slow or absent pulse. The slow pulse (30-40 per minute) may persist between attacks. The patient feels fairly

well. When a change in pulse rate occurs suddenly, the patient experiences symptoms. The diagnosis is established with certainty when an attack is recorded on an electrocardiograph and the site of the block is observed.

Treatment

Acute Stage

The purpose of treatment is to stimulate the ventricles to contract. This can be done by mechanical means such as striking the patient over the heart region, or administering an electrical shock to the heart muscle. Certain drugs which either stimulate the heart or prevent block may be used. The method of treatment depends on the circumstances of the attack.

Mechanical Treatment

The simplest and most effective way to restore heart function is by massage. Formerly, this was done by opening the chest and massaging the heart directly. However, massage can be done externally[1]. After the diagnosis of cardiac arrest has been made, the patient is placed quickly in a supine position on a hard surface. The floor is most convenient, a bed will not do. Hard, sharp pushes (50-60 times per minute) are applied to the lower left sternal edge over the heart. The effectiveness of this method is measured by obtaining a peripheral pulse and a recordable blood pressure. The patient's airway must be kept open. If he is not breathing some form of ventilation, such as mouth-to-mouth breathing, must be used. In many cases, a hard blow to the chest may start the heart. Such drastic measures can fracture ribs or cause bruising but it is a small price to pay. These procedures should only be used for emergency situations or when other methods fail.

A second method of mechanical stimulation is by electrical shock. This can be done externally through an electrode placed on the skin, or directly through a wire to the heart muscle. External cardiac stimulators are becoming standard hospital equipment. Usually the machines are designed to monitor the patient's electrocardiogram. The stimulator turns on automatically if the heart stops. The machine delivers a shock of 45 to 100 volts to the skin electrodes at any set rate. The effectiveness is measured by obtaining a peripheral pulse. The stimulation, while effective is quite painful. The discomfort can be kept to the minimum by applying electrode paste under the electrode so that the skin resistance is low. A severe skin burn will result if this is not done and the instrument will work poorly. Such equipment is useful for patients who have frequent attacks in hospital. It treats the attack promptly and is often life-saving. Because the method is painful, in severe cases an electrode catheter may be inserted through a vein into the right ventricle or a wire may be placed into the wall of the ventricle through a needle into the chest. These methods are painless and require one-tenth the current used externally.

Drugs

The agents used for this condition act to increase the irritability of the heart muscle so that, if a block occurs, it will quickly resume its beat.

Isuprel (Isoproterenol): This is the preferred drug in treating Stokes-Adams attacks. It can be given intravenously, subcutaneously, sublingually or in a rectal suppository. It is related to adrenalin and acts to restore the conducting system to normal. It acts quickly if given orally but its duration of action is short. When a patient has repeated attacks or a persistent slow pulse rate, Isuprel is best given in an intravenous drip of 5 per cent glucose and water at a concentration of 0.2 mg. to 4 mg. in 500 cc. The amount or the rate of drip is determined by the requirements of the individual patient in order to keep his pulse at a normal rate. When an attack occurs the rate of administration is increased. Once the attacks have become infrequent 10 mg. sublingual tablets are used. Duration of action is two to four hours. These tablets can be used as required by the patient for attacks occurring outside of hospital.

Ephedrine: This drug is also similar in action to adrenalin. The usual dose is 15 to 30 mg. q.i.d. It has the advantage of a longer duration of action than Isuprel. Its major disadvantages are that it is less effective, and that it has a tendency to cause extrasystoles. If given before bedtime it may keep the patient awake. In some patients distention and

constipation may be a problem following its use.

Other agents: Some success has been achieved by giving one-sixth molar sodium lactate intravenously for acute attacks. Adrenalin may be used but has many dangerous side effects. It should not be used with Isuprel or ephedrine. Because some attacks are thought to be caused by edema of the conducting system, cortisone has been given to patients to decrease edema. It is well-known that if the serum potassium is low the heart becomes irritable. Consequently some doctors give chlorothiazide to lower the potassium level and thus prevent attacks.

If a relationship can be shown between the attacks and a sensitive carotid sinus, the attacks can be abolished by blocking the vagus nerve with atropine or by cutting its fibres. It may be necessary to try several types of therapy before the effective one is found for an individual patient. Digitalis causes blocking at the atrioventricular node, therefore it should be used with great caution.

Chronic Stage

If attacks become frequent in spite of treatment with such agents as Isuprel, some form of continuous electrical heart pacing may be necessary. The development of transistors and mercury batteries has made it possible to build small portable pacemakers. With an electrode catheter in the right ventricle, a portable pacemaker, which the patient wears strapped to his body, can be used even for those receiving outpatient care. The patient is kept on anticoagulants to prevent clots forming on the catheter. Prophylaxis with antibiotics is required to prevent infections at the site where the catheter leaves the skin. Recently, Silastic-coated small pacemakers have been developed. These instruments contain mercury batteries that will last for five years. The pacemaker is buried subcutaneously in the abdominal wall with the wires running up under the skin to the heart muscle where they are implanted. Such an arrangement is very safe and, more important, allows the patient to escape from his condition.

Conclusion

The patient with Stokes-Adams syndrome leads a very hazardous life. He must be protected since fainting can occur at any time and result in injury. Activities such as driving a car must be forbidden. Even a very stable personality is tried to the breaking point by the constant fear of dying during an attack. It is understandable that suicide is a common cause of death in patients suffering from this disease.

It is of great importance that the nurses who care for patients who have such attacks should inspire confidence. Such confidence can be generated by a thorough knowledge of the disease and its treatment. The patient is aware that his life depends on the action of the person who is with him when an attack occurs. Since this is usually the nurse, she must be prepared to start treatment herself. The delay in obtaining medical help, without treatment in the interim, may prove fatal to the patient. The nurse's aura of confidence helps to break down the patient's fear and lessens his anxiety. Many of these patients must be referred to psychiatric units because of their anxiety.

There are a number of ways of treating Stokes-Adams syndrome. Modern developments have increased the rate of success. It is important that efforts be continued so that these patients can be rescued from this horrible condition and returned to a normal life.

Reference

1. N. B. Kouwenhoven, J. R. Jude, and G. G. Knicherbocher. Closed chest cardiac massage. *J.A.M.A.*, 173:1064, 1960.

Understanding must be the real goal of education. What is the use of doing, if you cannot tell whether you are doing right or wrong, good or harm? What is the use of earning a living, if you do not know how to live, having earned it? — C. H. GRANDGENT

If we are to abolish the death penalty, let our friends the murderers make the first move. — ALPHONSE KARR

* * *

Life is a pill which none of us can bear to swallow without gilding.—SAMUEL JOHNSON

Nursing Care in STOKES-ADAMS SYNDROME

MARJORIE NICHOLSON

In the successful treatment of patients with this particular condition, the nursing care is an important factor.

MR. TOMASEK was a 68-year-old Polish widower who immigrated to Canada in 1950. He was apparently in good health until 1953 when he experienced one period of unconsciousness. Fainting did not occur again until 1958. During the next two years he had frequent attacks of varying severity. It is interesting to note that while he was in a Siberian work camp in the early 1940's a doctor, who was also imprisoned there, told him that he had "something wrong with the electric nerve impulses of the heart."

On admission to another hospital in 1959 he required continuous external pacemaker stimulation for 88 hours. During this therapy a one-half hour power failure occurred. A heart beat was maintained by striking his chest 30 times per minute. At a later date, he required 89 hours of continuous external stimulation before an adequate ventricular rhythm was restored. Following these episodes he was placed on ephedrine and Isuprel therapy. He was discharged using a portable pacemaker which he carried with him constantly and which could be used externally to treat a severe Stokes-Adams attack. His first admission to the Royal Victoria Hospital, Montreal in January 1960 was preceded by several episodes of syncope.

Mr. Tomasek was a small, well-developed man with a mild scoliosis. His pulse rate was irregular with a range of 40-50 beats per minute. He gave no history of other diseases. All laboratory tests were within normal limits.

Treatment and Management

A. *January 1960 to March 1960*

1. Ephedrine sulfate 15 mgm. q.3 h., increased for a period to the high dose of 120 mgm. q.3 h.

2. Isuprel (sublingually) 10 mgm., alternating with the ephedrine, q.3 h. and p.r.n. to maintain the pulse rate above 40 per minute. The drug was also administered intravenously in concentrations at times as high as 2.8 mgm. per 500 cc. of fluid. The usual concentration is .4 mgm. in 500 cc. of fluid. The rate of infusion was regulated to maintain a pulse rate of 50 per minute.

3. Barbiturate and tranquilizing drug preparations regularly for sedation.

4. Methyl prednisolone and 1/6 molar-sodium lactate administered with no effect.

5. Continual monitoring of cardiac action and automatic external stimulation when asystole occurred.

During this three-month period, Mr. Tomasek experienced 28 periods of asystole. Each time he was promptly revived by external stimulation. The patient could always tell when an attack was imminent by a feeling of light-headedness and tingling in his legs occurring a few seconds prior to the episode.

In spite of sedation he was extremely apprehensive and demanding. He was continually preoccupied with counting his pulse and timing the rate of his intravenous infusion. Due to the frequency of his attacks he was restricted to bed rest.

B. *March 1960 to April 1961*

1. On March 30, 1960 an electrode catheter was inserted via the right external jugular vein so that the tip touched the endocardium of the right ventricle of the heart. A braided steel wire was inserted subcutaneously in the right anterior chest wall as a ground. With this arrangement it was possible to treat the patient with continual internal pacemaker stimulation. Initially, a pacemaker the size of a portable radio was used. Later, a small transistor battery pacemaker, five inches by four inches, was substituted for this machine. It was secured in a leather holster which was strapped around the patient's waist. Using this type of stimulation, the patient was free of

severe problems for 13 months. The electrode catheter was changed once and the skin electrode wire was changed four times.

2. Oral penicillin was given during this time as prophylaxis against infection at the catheter insertion and skin electrode sites. No infection occurred in the 13 months.

3. The patient was kept on continuous anticoagulant therapy to prevent clot formation around the catheter.

4. Again, sedatives were necessary. However, during this period he was adequately sedated by average doses of preparations.

5. Mr. Tomasek was discharged in July 1960 with instructions to come back to the ward weekly. At each visit the Cardiology Department's electrical engineer checked the pacemaker connections and tested the batteries. The batteries were changed every three weeks, although their life was at least six weeks. Dressings were changed weekly.

While this therapy was being used, a number of mechanical problems in equipment developed that caused episodes varying from dizziness to unconsciousness. Mr. Tomasek was admitted to hospital four times for observation. He gradually lost confidence in his pacemaker and became quite apprehensive and very difficult to manage. At any time of the day or night he would come to us with a problem, real or imagined. It was decided to change the method of continual artificial cardiac stimulation to the newer and improved implanted pacemaker.

C. *April 1961 and after*

A small transistorized pacemaker, approximately four inches in diameter and covered with inert plastic, was imbedded beneath the skin of the abdomen. Insulated wires from it were directed under the skin into the chest cavity. Through a thoracotomy incision the two wires were securely imbedded in the ventricular muscle.

The postoperative course was uneventful. The patient received the routine care following a thoracotomy. A careful check of pulse rate was made. The rate of stimulation of the pacemaker was set at 58 per minute. The patient required much persuasion and encouragement. He gradually became ambulatory and returned to a normal diet. After the incisions had healed, he enjoyed the first tub bath that he had had in over a year. This is possible now since the pacemaker and all wires are imbedded beneath the skin. He was discharged on his 20th postoperative day with no medication.

Mr. Tomasek is a different man. He has regained confidence since he does not continually fear a Stokes-Adams attack. However, he still is conscious of his pulse rate but this is understandable. He is seen routinely in the cardiac clinic for follow-up care, but he is not as dependent upon the medical and nursing staff as he was previously.

General Nursing Care

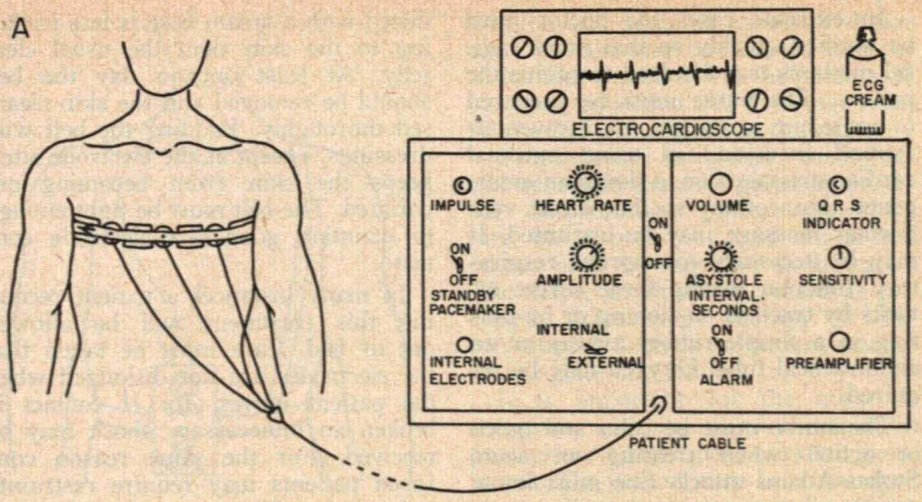
The most important factor in caring for a patient with Stokes-Adams syndrome is that each nurse should have sufficient knowledge of the condition; of required medications and their use, and of the various electrical stimulators so that she can feel secure herself. In this way she gives confidence and encouragement to her patient.

The patients with previously diagnosed Stokes-Adams syndrome, who are on medical therapy and who are admitted following a severe episode, are always extremely frightened. In many instances they know that the attacks are caused by their hearts ceasing to beat momentarily. It is generally known that life will end when the heart stops beating. Therefore these people have the constant fear that their hearts may not resume work and they will die. They have the added dread that an attack may occur while they are in potentially dangerous situations, such as while crossing a busy street. They are apprehensive and, in some cases, so preoccupied with their condition that psychiatric help will be required. Most of them need sedation.

The patients who come to hospital after an initial acute period of asystole know little or nothing about their condition. However, the treatment used as well as the recurring periods of unconsciousness are extremely frightening.

A. *The Acutely Ill Patient*

During this phase, oral and intra-



A. *External monitor pacemaker and electrode belt showing position of electrodes on patient's chest.*

venous medications and the external cardiac monitor-pacemaker are the main methods of treatment and maintenance.

The use of the pacemaker should be explained to the patient as soon as he is well enough to understand. It is important to estimate the amount of knowledge that each patient requires in order to give him confidence. Some are satisfied if they know only that the machine will give them electrical shocks to start the heartbeat when an attack occurs. Others are not at ease until they know all about the mechanism and, indeed, can almost read the monitored electrocardiogram themselves! All patients must be confident that the people caring for them know how to use the pacemaker and know what to do if asystole occurs. Since Stokes-Adams attacks happen at any time it is certain that a member of the medical staff will not be present for every episode. The nurse must often deal with it by herself.

Frequently the pulse rate drops gradually prior to an attack. The rate must be recorded regularly, sometimes as often as every 10 minutes. If the rate is dangerously low, for example below 40 per minute, the Isuprel infusion rate can be increased or Isuprel tablets given sublingually. This may increase the rate and prevent an attack. Care must be taken in titrating the pulse rate with Isuprel. If too much is given too quickly, tachycardia will result. The medication must be stopped, which causes a drop in the pulse rate, and the cycle begins again. For example, an increase in rate of the Isuprel intravenous infusion from 14 to 16 drops per minute is often sufficient to raise the pulse to a safe level. Great care and patience are necessary for best results.

When asystole occurs and the external cardiac monitor-pacemaker is being used, the machine's alarm will sound. Simultaneously artificial electrical cardiac stimulation will start at the rate and voltage set for this particular patient. The alarm must be loud enough to be heard throughout the ward. The nurse must assess the situation quickly and calmly. Perhaps the chest electrodes have been dislodged, which breaks conduction and sets off the alarm. In this case the patient must be reassured and the electrodes correctly replaced. If a true asystole has occurred and the patient has been revived by the stimulation already received, the machine can be turned off. Vital signs must be recorded, the patient must be made comfortable and the doctor must be notified. If cardiac action has not been resumed the stimulation must continue until a peripheral pulse is obtainable. It may be necessary to increase the amperage of the machine; to give the patient sublingual Isuprel; to increase the rate of the intravenous Isuprel infusion.

In extreme cases the doctor must be notified quickly so that more radical methods may be used to revive the patient. The nurse must be prepared to assist him in starting an intravenous Isuprel infusion; in using external cardiac massage; or in doing an emergency thoracotomy so that direct ventricular massage may be instituted. It may be necessary to improve respiratory function during these severe attacks by tracheal suctioning or by putting in a simple rubber airway or an endotracheal tube. Oxygen may be required.

The nurse must be calm and quick in action when treating an acute Stokes-Adams attack. She must know exactly where emergency equipment is kept, and obtain it promptly if necessary. Tracheal suctioning equipment, oxygen, rubber airways, endotracheal tubes and laryngoscope, an emergency thoracotomy tray, intravenous equipment and emergency cardiac drugs such as Isuprel, adrenalin and Pronestyl should be readily available.

When the attack is over, whether it has been slight or so severe that unconsciousness resulted, the patient will be frightened. He must be reassured and made comfortable. The Isuprel dosage must be regulated and the monitor-pacemaker setting checked in readiness for any further attacks. Observations regarding the attack and its treatment should be charted accurately and completely.

At times the maintenance medications, Isuprel and ephedrine, are ordered as often as every hour alternately. These must be given on time for optimal effect. It must be remembered that if Isuprel is taken *orally*, rather than sublingually, no effect will result because the gastric secretions destroy the drug. Large doses of ephedrine frequently cause intestinal disturbances such as distention and constipation. Local warmth, warm drinks, laxatives or enemas may alleviate these effects.

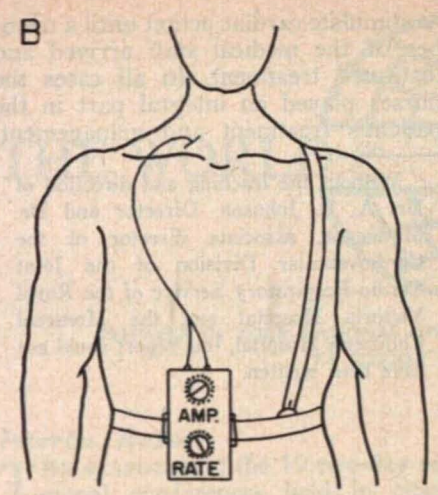
The three disk-like electrodes used with the monitor-pacemaker are attached to the patient's chest by a perforated rubber strap which encircles the thorax. Electrode jelly is used to ensure conduction. It must be renewed approximately every six hours. We have found that a brand of jelly produced with a cream base is less irritating to the skin than the usual clear jelly. At least once a day the belt should be removed and the skin cleansed thoroughly. Padding the belt with dressings, except at the electrode sites, keeps the skin from becoming excoriated. The belt must be tight enough to maintain good skin-electrode contact.

In many instances a patient receiving this treatment will be allowed out of bed. Care must be taken that the electrodes are not dislodged when the patient moves, for if contact is broken an unnecessary shock may be received. For the same reason confused patients may require restraints to keep them from removing the electrodes or belt. A patient who has infrequent attacks may be allowed bathroom privileges. The monitoring of cardiac function is interrupted for short intervals. During this time the patient must be closely observed in case an attack occurs.

B. *The Patient with an Indwelling Cardiac Electrode*

The procedure of inserting the electrode catheter and skin electrode wire is done under local anesthesia. Usually it disturbs the patient very little. The continuous heart pacing is achieved by connecting the catheter to a pacemaker stimulator. Ambulation should be increased gradually. A great deal of support and encouragement is required to give confidence to the patient who may have been bedridden previously because of frequent Stokes-Adams attacks.

When the incisions around the catheter insertion and skin electrode sites have healed, the dressings may be left in place for as long as a week. They must be light but secure. The skin should be thoroughly cleansed each time the dressing is removed. Ether will remove adhesive. Tincture of benzoin compound may be applied to the areas where strapping is necessary to protect the skin from irritation. A dry dressing is all that is necessary if no infection is present. An antibiotic ointment may be used as prophylaxis against infection. If the electrode catheter is not sutured in position it must be securely taped to the skin to prevent dislodging it from the optimal



B. *Transistorized pacemaker attached to intracardiac electrode catheter in the external jugular vein, with subcutaneous ground wire in right pectoral region. (Dressings removed).*

position within the heart. If any untoward change in the wound or catheter position is noted, the doctor must be notified.

When the patient has confidence in his pacemaker he may be discharged and given follow-up care on an outpatient basis. Before discharge he may be given a small transistorized pacemaker which he wears strapped around his waist.

The nurse must make certain that the patient realizes the importance of taking all the medications that are ordered; of continuing his anticoagulant therapy; of reporting for the routine change of dressing and pacemaker checks.

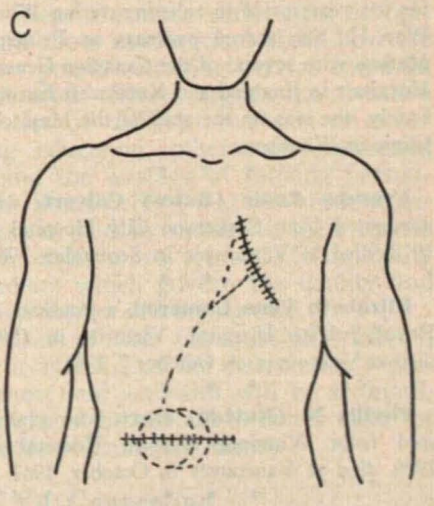
C. *The Patient with an Implanted Pacemaker*

Before operation an explanation of the pacemaker will benefit the patient. He may be incredulous about this tiny instrument's ability to provide him with a regular, dependable heart beat.

The patient's postoperative care is similar to that in any case of thoracotomy. In addition his pulse and general cardiac function must be checked frequently. A chest drainage tube connected to an underwater seal drainage bottle is used. This equipment must be checked at least hourly for the first 48 hours, noting oscillation with each respiration and signs of excessive drainage. A drain may be inserted into the abdominal wound where the pacemaker has been imbedded. All dressings must be checked for excessive drainage.

Prophylactic antibiotics, analgesics and sedatives must be given as ordered. Temperature, pulse, respiratory rate, blood pressure, fluid intake and output must be recorded as indicated. The diet is gradually increased as tolerated. Intravenous therapy is discontinued as soon as the patient reaches an adequate oral intake.

It is important for the nurse to cooperate with the physiotherapist in precautions against postoperative pneumonia. The patient must be encouraged to cough and to do deep breathing exercises. While in bed, he must be turned at least every two hours. Barring complications it is usually possible to begin ambulation on the third postoperative day. Again, support and encouragement are necessary to give the patient confidence.



C. *Patient showing position of transistorized implant pacemaker and myocardial electrodes. The entire instrument imbedded beneath the subcutaneous tissue through two skin incisions, as illustrated.*

This type of pacemaker is designed to increase its rate of stimulation when the transistor batteries start to run down. The patient should be told to check his pulse daily and to seek medical help if the rate increases. He will be advised to come to clinic or to visit the doctor for routine follow-up care.

Discharge, when the success of the pacemaker is assured, returns the formerly insecure and apprehensive patient to an almost normal life.

Summary

During the past year 15 patients suffering from Stokes-Adams syndrome have been treated in this hospital using all or some of the methods described. In one case a nurse was instrumental in reviving the patient during a severe period of asystole when she struck the patient's chest to stimulate cardiac action until a member of the medical staff arrived and instituted treatment. In all cases the nurses played an integral part in the patient's treatment and management.

Without the teaching and direction of Dr. A. L. Johnson, Director and Dr. McGregor, associate director of the Cardiovascular Division of the Joint Cardio-Respiratory Service of the Royal Victoria Hospital and the Montreal Children's Hospital, this report could not have been written.

In Memoriam

Dorothy Forsythe Ballantine, A.R.R.C. formerly matron-in-chief of the RCAMC, died suddenly in Winnipeg on October 31, 1961. A 1930 graduate of Winnipeg General Hospital, Miss Ballantine specialized in operating room work and was a supervisor for ten years prior to enlisting during World War II. She served overseas as Principal Matron with several of the Canadian General Hospitals in England and Northwest Europe. Lately, she was on the staff of the Manitoba Clinic in Winnipeg.

* * *

Frances Annie (Bates) Calvert, who graduated from Saskatoon City Hospital in 1912, died at Vancouver in September 1961.

* * *

Elizabeth Vena Cameron, a graduate of Royal Jubilee Hospital, Victoria, in 1904, died at Vancouver on October 7, 1961.

* * *

Phyllis N. (Ruttan) Hart, who graduated from Winnipeg General Hospital in 1926, died at Vancouver in October, 1961.

* * *

Edna Agnes Lewis, a 1928 graduate of Brantford General Hospital, died at Brantford on March 16, 1961.

* * *

Frances (Bond) Lind, a 1909 graduate of Vancouver General Hospital, died last year. Mrs. Lind was the first probationer accepted into the school after the hospital was moved to its present site in 1906.

* * *

Margaret (Scott) Norton, a graduate of Toronto Western Hospital, died at Brantford on June 11, 1961. At the time of her retirement in 1956, Mrs. Norton was supervisor of public health nursing with Brant County Health Unit.

* * *

Helen Ann (McKeown) McDonald, who graduated from St. Vincent de Paul Hospital, Brockville, Ont. in 1933, died there on October 1, 1961 after a brief illness.

* * *

Lillian May (Anderson) Moninger, a graduate in 1925 from the General Hospital, Pembroke, Ont. died recently. Mrs. Moninger had engaged in private nursing.

* * *

Margaret O'Meara, who graduated from St. Michael's Hospital, Toronto in 1904, died on September 29, 1961.

* * *

Isobel Orr, a graduate of St. Vincent de Paul Hospital, Brockville in 1927, died at Kingston on August 20, 1961 following a lengthy illness.

* * *

Patricia Jeanne Mary (Clark) Rayner, who graduated from Medicine Hat General Hospital in 1940, died in Vancouver on October 26, 1961.

* * *

Teresa Mary Roach, a graduate of Spencer Hospital, Meadville, Pa. died in Toronto last year. She had engaged in institutional nursing in Ontario for many years.

* * *

Flora J. Thompson, a 1920 graduate of the Montreal General Hospital, died in Montreal during November 1960.

* * *

Ethelyn M. (Knight) Woodworth who graduated from Vancouver General Hospital, in 1920, died on July 8, 1961.

THE WORLD OF NURSING

PREPARED IN YOUR NATIONAL OFFICE, CANADIAN NURSES' ASSOCIATION,
74 STANLEY AVENUE, OTTAWA

Interim Report

THE RESPONSE to the 19 two-day regional conferences held in cities across Canada for interpretation of the CNA School Improvement Program was very enthusiastic. The conferences were attended by deputy ministers of health and education, chairmen of boards of control and hospital administrators, directors of nursing and faculty members of the schools.

GLENNA ROWSELL, director of the program reports that there has been a growing awarenes of the needs to improve teaching programs and everyone seemed to welcome the study conferences.

The 156 participating schools of nursing are now working on the self-evaluation guides which will be completed and sent in to National Office by May 1962 for review by a special panel.

Royal Commission on Health Services

A preliminary meeting of this Commission was held in Ottawa on September 27 and 28. The purpose of this meeting was to outline the procedure that will be followed and the principles that will govern the Commission in its public hearings. No briefs were asked for at this meeting; interested parties were invited to give statements of principle which they felt should guide the Commission as well as their view as to the areas and problems which should be covered, in line with the Commission's terms of reference.

The Canadian Nurses' Association was represented at the hearing by HELEN M. CARPENTER, President, and M. PEARL STIVER Executive Director. Miss Carpenter made a preliminary statement to the Commission indicating our intention to submit a formal brief at the appropriate time and outlining some of the areas which we felt should be covered in the investigation.

The Commission, appointed against a background of public interest may well prove to be one of the most important examinations of health care in Canada. Its deliberations and recommendations may affect nursing in Canada for years to come.

There are many differences of opinion about nursing and about how the best possible nursing service could be achieved. Some argue the relative merits of different methods of nursing education, others are concerned about the wastage of nursing personnel. Some believe that too much attention is paid by nurses to their economic welfare and too little to the many factors which govern the quality and distribution of nursing care.

Out of the Commission's efforts, it is hoped that the Association's programs and activities will be strengthened and broadened to better meet the needs of Canadian nurses.

CNA Convention

The Program Committee, acting upon the expressed wishes of the majority, has selected *Nursing Service* as the main theme. It is hoped that the various approaches to this timely theme will prove stimulating and of genuine interest to all nurses.

Reception and registration will commence on Sunday, June 24, 1962 at the Queen Elizabeth Auditorium, Vancouver.

Registration fee: Registered Nurses, $15.00; Student Nurses, $8.00. Students who will be attending are re-

quested to submit their application to National Office prior to June 22, 1962. All nurses are invited to use the advance registration and accommodation application forms from this issue. Early registration is to your advantage.

Accommodation: National Office has reserved a large number of rooms for the convention. As soon as the "Request for Accommodation" form is received, National Office will send confirmation of the reservation directly to the applicant. Every possible effort will be made to ensure that applicants are supplied with the type of accommodation requested. Priority will be given in the order of receipt of such requests although actual accommodation cannot be assigned until there is a fairly accurate indication of the probable number of registrants requiring rooms. Don't delay! Use the form at once.

Entertainment: A varied program of cultural and social entertainment will be offered throughout the week of the Congress. A list of current events and places of interest will be circulated at registration. Tickets will be on sale for special events.

HOTELS

		Minimum Rates			
		With Bath		Without Bath	
Name	Comments	Single	Twin	Single	Twin
VANCOUVER			$12.50		
GEORGIA			11.50		
DEVONSHIRE	Triples & Suites available	$ 7.50	11.50		
GROSVENOR	Central	6.50	10.00	$4.00	
ALCAZAR	Near Q. E. Theatre	5.00	7.00	3.00	$5.50
ABBOTSFORD	Central	8.00	8.50	5.50	
CASTLE	Central	5.00	8.00	4.00	
RAMADA INN	Near Vancouver Hotel		12.00		
	Triple		15.00		
GEORGIAN TOWERS	Suites only $3.00 per person over 2 per suite	11.00	13.00		

MOTELS*

BURRARD	12 Blocks to Q. E. Theatre	7.00	13.00		
	Double with Hide-A-Bed		11.00		
DORIC HOWE MOTOR	15 min. to Q. E. Theatre $1.50 each over 2 people		13.00		
SANDS	$2.00 per person over 2 per room. On English Bay.	8.50	10.50		
KAMLO MOTOR	On English Bay	6.50	8.50		
SURF APARTMENTS	On English Bay Suites with Kitchen (3)		8.50		
	Suites with Kitchen (4)		11.00		
FRASER ARMS 1450 S.W.1. Marine Drive	10 min. drive to Q. E. Theatre		7.50		
	3 Bedded room		10.50		
SKYLINE 303 No. 3 Road Richmond	20 min. drive to Q. E. Theatre over toll bridge		10.50		

*Deposit required for 1 day for all motels.

Other attractive Motels available in West and North Vancouver across Lion's Gate Bridge, a toll bridge where traffic is heavy morning and evening. We would, however, be pleased to make reservations at your request.

CONVENTION - 1962 - REGISTRATION
CANADIAN NURSES' ASSOCIATION

31st BIENNIAL MEETING
QUEEN ELIZABETH THEATRE
VANCOUVER, BRITISH COLUMBIA
JUNE 24th - 29th, 1962

For Office Use Only
Material sent
Date

NAME
(PLEASE PRINT)

ADDRESS

.....

C.N.A. MEMBERSHIP: ACTIVE..... ASSOCIATE..... HONORARY

CLASSIFICATION
(PLEASE INSERT CHECK MARK WHERE APPLICABLE)

HOSPITAL PRIVATE NURSING PUBLIC HEALTH

OCCUPATIONAL OTHER (Specify) STUDENT

GENERAL STAFF..... SUPERVISION..... TEACHING..... ADMINISTRATION.....

KINDLY ENCLOSE REGISTRATION FEE: R.N. $15.00; STUDENT $8.00

MAKE CHEQUE PAYABLE TO:—

CANADIAN NURSES' ASSOCIATION,
74 STANLEY AVENUE,
OTTAWA 2, CANADA.

NO REFUNDS AFTER JUNE 22, 1962.

The RNABC Arrangements Committee is working closely with National Office to provide comfortable accommodation for nurses attending the 1962 Convention in Vancouver, June 24th - 29th.

Reservations are being held for us in Vancouver at the Vancouver, Georgia, Devonshire, Grosvenor and other hotels and motels.

Naturally, at a large convention, single rooms are at a premium. It will be helpful if two nurses will arrange to room together and indicate this on the registration card overleaf.

(over)

CONVENTION ACCOMMODATION, 1962

VANCOUVER, BRITISH COLUMBIA
JUNE 24th - 29th, 1962

For Office Use Only
Reservation made
Date

REQUEST FOR ACCOMMODATION

NAME POSITION
(PLEASE PRINT)

ADDRESS

.....

NAME AND ADDRESS OF PERSON WITH WHOM ACCOMMODATION WILL BE SHARED:

.....

.....

TYPE OF ACCOMMODATION: HOTEL MOTEL
(PLEASE INDICATE 1st & 2nd CHOICE)

	SINGLE	TWIN BEDS	DOUBLE BEDS	NUMBER OF PERSONS	PRICE RANGE
BATH					
NO BATH					

MEMBERS OF NURSING SISTERHOODS PLEASE INDICATE ORDER TO WHICH YOU BELONG:

.....

ARRIVAL DATE HOUR

DEPARTURE DATE HOUR

BY: TRAIN
AIRLINE
BUS
MOTOR

— PLEASE RESERVE EARLY —

IMPORTANT

STATE DATE AND HOUR OF ARRIVAL AND DEPARTURE, IN ORDER THAT ACCOMMODATION MAY BE RESERVED.

MAIL THIS FORM TO:

CANADIAN NURSES' ASSOCIATION,
74 STANLEY AVENUE,
OTTAWA 2, CANADA.

NURSING PROFILES

In November, 1961, **Marion Clarke** became the director of nursing at the Toronto Psychiatric Hospital.

Miss Clarke completed her basic nursing course at Mount St. Vincent College, Halifax, which included six months of psychiatric nursing at the Nova Scotia Hospital. After receiving her degree in 1955 she taught nursing arts at the Nova Scotia Hospital for two years.

In 1958, following a year of study in education and administration at the University of Toronto, Miss Clarke was appointed nursing instructor at the Toronto Psychiatric Hospital. In her new position she has replaced Miss **Grace Sagert** who has retired.



ISABEL HAGAN

M. Isabel Hagan was recently appointed assistant director Nursing Service at the Toronto General Hospital. A native of Toronto, Miss Hagan graduated from T.G.H. in 1953 and has remained on staff there since. She has gained experience in nursing service as a general staff nurse, assistant head nurse and head nurse.

In May, 1961 Miss Hagan was awarded a diploma in Nursing Service Administration from the University of Western Ontario. She has been active with the Registered Nurses' Association of Ontario and the T.G.H. Alumnae Association.

In her leisure time Miss Hagan enjoys reading, music and travelling.

Ruby Frances Harnett is Newfoundland's newly appointed editorial advisor to *The Canadian Nurse*. Active in nursing association work, Miss Harnett brings a wealth of experience to the *Journal*.

A native of St. John's and a graduate of Grace Hospital there, Miss Harnett has been Associate Director, Departmental Nursing Service, Department of Health since 1956. She is vice-president of the St. John's Chapter, Association of Registered Nurses of Newfoundland, president of her Alumnae Association, and a member of the Board of Management, St. John's Branch of the V.O.N.

Miss Harnett enjoys reading and handicrafts as well as being a hockey enthusiast.

The newly-appointed French-language editorial advisor to the *Journal* from the province of Quebec is **Florita Vialle-Soubranne.** A native of Jonquière, Quebec, she attended school in Chicoutimi and Montreal.

Mrs. Vialle-Soubranne graduated from St. Justine's Hospital, Montreal, then took a postgraduate course in medical nursing at Notre Dame Hospital, Montreal. She was awarded a Bachelor's degree in nursing from the Marguerite d'Youville Institute in 1959.

Nursing service and nursing education both form part of the background she brings to



(Herbert Schroeter, Roxboro)

FLORITA VIALLE-SOUBRANNE

the *Journal*. She has been a head nurse, clinical instructor in medicine, and clinical coordinator at St. Justine's. In the past three years, as a faculty member there, she has taught medical nursing, pharmacology and pathology.

From 1957-60 she was a Lt. Nursing Sister with No. 1 Medical Battalion (R.C.A.M.C.) (M) and in 1959 was a councillor of the Catholic Nurses' Association of Canada (Montreal section).

A member of the Camping Club of Canada Mrs. Vialle-Soubranne enjoys camping, using a kayak, and tennis. She is also a member of the Lakeshore Film Society and enjoys movies, the theatre and reading.

Two natives of Ontario joined the staff of the School of Nursing of the University of New Brunswick in July 1961.



MARGARET MACLACHLAN

Margaret Mowat MacLachlan was born in Strathroy and attended Renfrew Collegiate Institute and McMaster University. In 1937, she received her diploma from the School of Nursing, University of Toronto returning in 1947 to complete requirements for the degree of Bachelor of Science in Nursing. In 1959 she was awarded a Bachelor of Arts degree from U. of T., then a Master of Arts degree from the University of Washington, Seattle, in 1961.

To her new position as assistant professor, School of Nursing, UNB, Miss MacLachlan brings a varied background. Following graduation in nursing she spent three years with the Outpost Hospital Division of the Ontario Red Cross. She was staff nurse with the Cornwall Health Unit and the Cornwall Branch of the VON over a four-year period. From 1944-48 she was senior nurse with the Simcoe County School Health Service and for the next five years director of nursing of the Health Unit of the same county. From 1953-60 she was a lecturer at the School of Nursing of U. of T.

Miss MacLachlan has been active with RNAO having been chairman of the Barrie Chapter, member and chairman of the Personnel Policies Committee and a member of the Permanent Education Fund.

Helen Ailene Guernsey, a 1956 graduate of the Hospital for Sick Children, Toronto, is now a lecturer in nursing at U.N.B. A native of Wellington, Ontario, Miss Guernsey is an alumnus of Queen's University, which awarded her the degree of Bachelor of Nursing Science in 1961. Prior to obtaining a diploma in public health nursing from Queen's in 1958, she did general staff nursing at her home school. Clinical instruction occupied three years, first in the Infant Department at H.S.C. and latterly in the Obstetrical Department at the Kingston General Hospital.

Miss Guernsey's domestic interests are cooking and sewing, while outdoor activities include skating and swimming.



HELEN GUERNSEY

Two recent graduates of the University of British Columbia have joined the faculty of its School of Nursing.

In September 1959, **Tomiko Sugimoto,** a native of Raymond, Alberta and a graduate of the Lethbridge Municipal Hospital school

of nursing, became a clinical instructor at U.B.C.

Miss Sugimoto attends evening classes in Oriental studies, is a football fan and enjoys art and reading.

In July, 1960, **Helen Elizabeth Cawston** joined the faculty of U.B.C. as an instructor. Born in Calgary, Miss Cawston graduated from the Vancouver General Hospital and has worked in B.C. since. Following graduation she did general staff nursing at V.G.H. for two years, then had experience there as an assistant head nurse, assistant night supervisor, and head nurse.

From 1949 to 1950, Miss Cawston was building supervisor, Infectious Diseases Hospital of V.G.H. In 1951 she joined the staff of the Provincial Department of Health, Division of Venereal Disease Control. For two years she was a special treatment nurse, after which time she became Superintendent of Nurses, a position she held until her present appointment.

Miss Cawston was secretary, Provincial Instructors' Group of the RNABC 1958-59. She enjoys sewing and playing the violin in her leisure time.

Evelyn A. Pepper, R.R.C., was awarded the Pfizer Award of Merit at the Tenth Annual Conference of the U.S. Civil Defence Council in Los Angeles. Miss Pepper who is nursing consultant, Emergency Health Services Division, Department of National Health and Welfare, was honored for her contributions to medical-health and disaster preparedness.



EVELYN PEPPER

Well known to many Canadian nurses through the civil defence courses in Arnprior, she is chairman of the Registered Nurses' group of the Professional Institute of the Public Service of Canada.

What is the Canadian Conference on Education?

The Canadian Conference on Education began late in 1956 with a feeling on the part of a number of people, directly or indirectly concerned with education, that it was time for Canadians to get together to discuss education in all its aspects: past developments, present problems and prospects, future growth.

Representatives of 19 interested national organizations planned a national conference to be held in Ottawa in 1958. Eight "program commissions" of experts in their fields, were set up to study the subjects of Building and Equipment, Education for Leisure, Financing Education, Higher Education, Organization and Curricula, Role of the Home, Special Needs, and Teachers — Quantity and Quality.

The first meeting brought together 850 delegates from every province. It brought in 31 resolutions for implementation at all levels, covering such diverse subjects as student aid, teachers' salaries, learning a second language and research. It also urged the establishment of a continuing organization to carry on the work. Any national organization professing an interest in education and a willingness to take part in the Conference's work was welcomed. The Canadian Nurses' Association is one of the sponsors.

A second national conference will be held in Montreal, March 4-8, 1962. The Conference Studies Committee is responsible for organizing the preparation of nine major studies, to be published prior to the Conference, on the Aims of Education, Educational Research, Professional Status of Teachers, Development of Student Potential, Financing Education, Leadership in Education, Continuing Education, New Developments in Society, and Employment and Education.

The Professional School in the University

DAVID N. SOLOMON, PH.D.

A discussion of some of the consequences for universities and for professions, presented at the annual meeting of the Canadian Conference of University Schools of Nursing, in Montreal during June, 1961.

Introduction

MY PURPOSE is not to engage in the controversy over whether nursing should be taught in a professional school within a university rather than in a hospital school. That nursing is to join other professions whose new members are trained in university professional schools appears to be established in Canada and elsewhere.

The introduction of professional training into universities has, however, certain consequences for universities and for the professions concerned. In the first part of this article, where I shall undoubtedly appear to be somewhat partisan in my views, I propose to discuss some of the less desirable consequences of the presence of professional schools for other parts of the university. In the second part, I shall indicate *some* of the *possible* consequences for the nursing profession of having some of its members trained in universities.

Consequences for the University

Organization Purpose

An organization is to be distinguished from other forms of association by the fact that it has a specific purpose. It makes no sense to inquire into the specific purpose of a family, of a boy's gang, or of any other such association. While these have functions, they are not characterized by any specific and particular purpose. An industrial organization, on the other hand, does have a specific purpose, whether one regards it as making a profit, as the production of tangible goods, or as offering some kind of service.

The notion of a specific purpose is only part of the story. In the case of most organizations one should emphasize the multiplicity of sometimes competing purposes. When we say that an organization has a specific purpose what we really mean is that there is one identifiable purpose which has *primacy* over such others as can be identified.

A hospital is a good illustration of this kind of organization. The primary purpose of most hospitals is a service — therapy. Many hospitals also have, perhaps as a secondary purpose, the training of persons. It is unnecessary to enumerate the kinds of conflict which result from the competition between service and training, both of which are presumably legitimate purposes. In addition, many hospitals engage in research, the purpose of which is to advance knowledge, another obviously legitimate purpose which sometimes comes into competition with the others.

Purposes of Universities

The following statements are an attempt to catalogue what a university actually does, rather than a description of the purposes it ought to have. Universities differ in the degree of emphasis placed on each purpose and in the degree of success they have in carrying out their various purposes, but any university that is worthy of the name makes at least some contribution to each of the following three purposes.

1. Through its museums, libraries and in the person of its members, a university is a custodian of two kinds of knowledge — humanistic knowledge, which is often referred to as "culture" and knowledge which is of more or less immediate practical use, but still distinct from technology. For example, people of many societies have been able to ferment grapes and produce wine, to make glass or pottery, to navigate distant seas, without knowing why the combination of certain substances or actions, under certain conditions, produces a particular result. These procedures are empirical, rather than based on science — the principles which explain why the techniques work are not understood. Techniques can be very effective even though scien-

tific understanding is imperfect or lacking. But the body of techniques, usually referred to as technology, whether based on experience or scientific understanding, has only a minor role in a university. There is, of course, a place for efforts that increase understanding of principles which can quite readily be applied.

2. A university conducts research and scholarship intended to increase the store of knowledge and understanding. During the past century universities have become almost the only organizations which have the advancement of knowledge as their primary, specific purpose. This does not mean that individuals or other organizations do not make contributions, but only that they are minor.

3. A university transmits knowledge of various kinds, through the publications of its members, the training of students, etc. There are two kinds of training: *liberal education* designed to transmit "culture," and *vocational education* which is also of two kinds: The preparation of future scholars, researchers and university teachers. This insures the transmission of the store of knowledge to the oncoming generation and provides trained personnel to insure the continuity of the university and its tradition. The second type of vocational education is the training of experts and consists mainly of specialized education for professional service. This implies imparting knowledge and understanding as well as technique to people who will use this training in the service of others. Some of this training is truly professional in character, some of it technical.

Competition among Purposes

Competition among these purposes arises partly from the relations of the university with the outside world. These can be seen most easily if we think of the university as an organization which receives certain "in-puts" from, and which gives certain "out-puts" to other organizations in the society. The in-puts are personnel — students, teachers, and other staff members who come mainly from the schools or other universities — and financial resources which provide the necessary facilities and come from governments, private benefactors including industry, and fees. The out-puts of the university are the results of research and scholarship, and certain kinds of trained capacities. In a general and diffuse sort of way, society is the consumer of these out-puts. This is particularly true of liberal education, which as an out-put has no clear and specific destination.

Certain of the results of research and certain trained capacities, mainly those produced by the graduate and professional schools, constitute in-puts for other organizations, such as universities, government departments, industries, hospitals, and schools. These out-puts of the university, which are more or less immediately useful or can readily be made to serve practical purposes, are the ones which are most valued by those who have power over the resources (in-put) required by the university. As a consequence, a disproportionate share of the resources available goes to professional schools. The amounts of their grants indicate their approximate rank in the hierarchy of prestige of professions: medicine, engineering, social work, religion, nursing, and so on. I would not like to guess at the precise ranking in the prestige hierarchy, nor to make an estimate of where pure science, the humanities and the social sciences fit in, although the last two are clearly quite low. The presence of professional schools then, to some degree, results in the impoverishment of the facilities for liberal education which some professionals say they so much desire. It can also be argued that if the professional schools were absent their resources would be completely withdrawn and liberal education would be even worse off. There is little doubt that other faculties and departments benefit because important people are interested in, for example, medical or engineering research. The question of whether the other purposes of the university gain as much as they lose from the fact that professional schools are more attractive to benefactors, remains.

There is another way in which liberal education and other purposes suffer from the presence of professional schools and perhaps the graduate school in general. Since the output of the undergraduate part of the university is also the in-put for professional schools, mutual influence exists. The character of liberal arts students and of the undergraduate curri-

culum are influenced, to some degree by the requirements of the professional schools. On the other hand, the characters of the professional schools are affected by the kind of training their recruits have already had. Although there is a certain mutuality to this relationship, the professional schools are mainly cast in the role of making demands, if only through the ways in which their potential students choose courses and emphasis approaches which they believe, sometimes wrongly, are approved and desired by the professional schools. This may not be altogether a bad thing, but it does compete with the effort to advance knowledge and educate students who, unlike the pre-professionals, are in search of general or liberal education. Since pre-professional students are, perhaps, different and certainly have different interests and ambitions, the presence of large numbers of them may change the character of certain courses offered in the undergraduate curriculum.

Summary

While the relationship between professional education and the other purposes of a university has by no means been fully covered, I have tried to indicate that, in general, the other purposes of the university lose from the presence of professional schools. It is harder to maintain a clear sense of purpose, in some cases to maintain standards, and almost always it is more difficult to obtain a share of available resources. In a sentence — and this is what I meant when I said that my views are probably somewhat partisan — the professional school takes more than it gives. If, however, it sees its mission as being a *custodian* of knowledge and understanding, and not only technique, in its own field; as *advancing* its knowledge regardless of its practical character; and as *transmitting* knowledge and understanding as well as technique; then, by the presence of its faculty and students the professional school can make a real contribution to the life and character of the university and its competition for financial and other resources may be a tolerable loss.

It is not clear to what extent it is possible for professional schools and the people in them to behave in this way, nor is it clear just what contribution a school of nursing can make to a university. There are some signs, however, that professional schools can, if they choose, get away from narrow vocational (technical) training and contribute significantly to university life.

Consequences for the Nursing Profession

A definition that draws attention to certain basic elements of a profession can be used to indicate some of the possible undesirable consequences for a profession like nursing of having a few of its members trained in universities, while most are trained elsewhere. Present arrangements may produce two kinds of nurses and result in the creation of two kinds of nurse roles, thus altering the division of labor which presently provides medical care and putting an extreme strain on the viability of the profession.

Definition of a Profession

Precise defining of the term "profession" is often regarded as an impossible and useless task. Nevertheless, certain identifying characteristics can be isolated and there is some sense to them because of the way in which they fit together. A profession consists of four basic elements:

> 1. A set of persons bound together by informal ties and a formal association, who 2. possess a technique or an art which 3. they practice in the service of others 4. in accordance with a set of clearly-defined and formally-stated rules governing interactions with clients, colleagues, and others.

For the present purpose two of these elements are crucial ones. First, the question of technique or art based on knowledge. Every occupation requires some understanding of the basic principles involved and some knowledge of technique, irrespective of understanding. What differentiates occupations, particularly the more highly skilled occupations, is variation in the ratio of understanding to technique. In a profession this ratio is high. A great deal of what is done depends on the understanding of basic principles and much is a matter of technique. This is why it is possible for people to

masquerade as professionals. They are capable of learning the techniques, but presumably lack the understanding, which takes longer and is more difficult to acquire. At the other end of the scale are occupations which, although highly skilled, do not involve much understanding of basic principles but consist only, or mainly, of technique.

The fourth characteristic, the rules governing professional behavior, defines the fiduciary character of the relationship between the professional person and his client or patient. He is an expert with a purpose: to serve the best interests of clients. This type of rule requires highly-disciplined behavior on the part of professional persons. The disciplined or dedicated character of relations with others distinguishes professionals from mere experts.

The various occupations which are called, or aspire to be called, professions quite clearly fall along a continuum. Some exemplify the elements of the definition to a high degree, others depart considerably from this ideal picture. Carr-Saunders[2] speaks of a continuum consisting of old professions, new professions, quasi-professions and would-be professions. If we take the definition seriously, we can place an occupation in the category in which it belongs. We will find that either we know quite a bit about the character of it or at least are in a position to ask some interesting questions about it. The first question arises from the notion of the ratio of understanding to technique; the second has to do with the fiduciary character of the norms regulating the interactions of professionals with clients and others.

Technique and Knowledge

Some occupations which are in the process of becoming professionalized, or more professionalized, face problems which arise from the fact that the occupational roles of most of their members consist of techniques and administrative skills which are learned largely from experience, or can be, and which do not rest on any body of fundamental knowledge. This may be so for various reasons. Some roles require nothing more than technique, as is the case with morticians, for example, who would like to be regarded as professionals. In other instances, the roles could be better performed if there was a scientific basis to which practitioners could refer, but none exists. Social work illustrates this problem. Many decisions with regard to the welfare of clients — unmarried mothers, disintegrating families, juvenile delinquents — must be taken without the benefit of science because the required knowledge does not exist. Moreover, to the degree that social work roles consist of administration, they are twice caught in the same dilemma. There is no body of scientific knowledge from which the principles of administration can be derived. In their present state the social sciences simply do not provide answers for most practical problems.

If a role requires mainly technique, rather than knowledge and understanding, or if practice must be based on principles which are essentially empirical rather than scientific, what will it do to the occupation if some of its members are exposed to education in basic sciences which are not really required by the role as it is presently defined, as well as to education which prepares them, or gives them an advantage in competing for, administrative roles?

In the case of nursing, this may result in a redefinition of the role of the nurse so that there will be two nurse roles, and two nursing careers. The university-trained nurse may be more capable of taking responsibility for treatment and also in an advantageous position for promotion into administrative or specialized positions. This implies a redefinition of the division of labor which provides medical care and may involve professions other than nursing.

The Requirement for Disciplined Behavior

Under what conditions can the disciplined behavior required by the fiduciary character of the relationship between professionals and their clients be achieved and maintained? Training, in addition to imparting the basic knowledge and techniques of an occupation, if it is successful, instills the basic attitudes and values of the occu-

pation. Recruits not only become knowledgeable and technically skilled, they also become self-disciplined. However, self-discipline is usually not enough to ensure disciplined behavior after graduation. It must be sustained by the social arrangements for carrying out the work and, in particular, the kinds of rewards available to successful practitioners.

Between World Wars I and II, Canadian hospital schools of nursing seem to have succeeded in instilling a good deal of self-discipline and dedication in most, although certainly not all their graduates. However, the conditions of life in hospital schools of nursing are, I am told, now considerably changed. For one thing, much larger numbers of students are present. If the masses of nurses continue to be trained in hospitals, can hospital schools with large classes continue to produce even the degree of dedication and self-discipline that was possible in the earlier period? It seems to be possible to pass knowledge and technical skill to relatively large numbers of students. There is some question, however, as to whether, when numbers are large, conditions appropriate for instilling attitudes can be maintained, although certain elite military corps appear to have had a degree of success with this type of training. If the masses of nurses graduating in the next 20 years are not as professionalized in the sense of being dedicated as were their predecessors, what will they be like? What, in fact, are the masses of nurses really like now? Casual reading suggests that there is considerable variation. Some appear to have the attitudes of dedicated professionals; others seem to have the more impersonal approach of people who work for large organizations; some are a mixture of the two and other things as well.

On the other hand, if the universities train relatively small numbers of nurses and have them for a longer time, these may turn out to be the really professionally-disciplined people: an elite quite distinct from the mass of nurses.

Regardless of the degree of success in instilling self-discipline, a good deal depends on the conditions of daily life. One important motivating aspect of the social arrangements of daily work is access to the valued rewards of the work. If university-trained, elite nurses in addition to being the most professionalized, are also the most knowledgeable and have access to the more interesting parts of the work as well as being advantageously situated with reference to the possibilities of rapid promotion, then they will get the major share of the rewards of pay, prestige, promotion, and direct satisfaction from the work. If this should turn out to be the case, what will motivate the others who may emerge from training less professionalized and who, in the context of hospital organization, will presumably be medium or low-ranking organization women?

Summary

The implication of these questions is that the profession is likely to find itself composed of two kinds of nurses — who may be different kinds of persons at the time they start their nursing careers, who will emerge from the two kinds of training as different people, who will be capable of performing quite different kinds of roles, and whose ultimate fates or life-chances in the profession will be quite different. No profession, in any meaningful sense of the word, would be viable under such circumstances. Some adjustments will be required. Perhaps hospital-trained nurses, as is presently being done, can be given university education. This may be an *ad hoc* solution unlikely to last. Ultimately, some of these threatening problems may be solved by educating all nurses in university professional schools, leaving to hospitals the on-the-job or apprenticeship training of less skilled workers. This would almost certainly result in a drastic redefinition of the role of the nurse and some reorganization of the division of labor between the medical, paramedical, and medical administrative occupations.

Those who are opposed in principle to university schools of nursing may find comfort in these questions although this is not my intention. In attempting to raise provocative questions, I have chosen to stress undesirable consequences rather than to preach to the converted. I leave it to

others to make a case for the desirable consequences. I certainly do not mean to suggest that in the face of such questions we should consider abandoning the notion of professional schools of nursing in universities. I do suggest that the profession will need to take some very concrete steps to deal with such consequences if, indeed, they seem likely to arise.

Conclusion

The factual basis for some of my remarks was perhaps not always what it might have been, but that should be taken only as an indication that research is required and should be done by, or at least under the sponsorship of, those who have the greatest stake in the answers.

Nurses are now engaged in redefining their mission. Some sort of new division of labor is coming about, or is on the horizon, in medical service in general. This field is swarming with new and redefined roles. The present immense confusion results from the rapidity of social change. The present division of labor may be radically changed in the future. Aside from the questions of who shall perform the administrative roles required in hospitals and what kinds of training are most appropriate to prepare these people, it may not be entirely out of place to ask whether or not consideration might be given to some set of roles involving therapy which would fit in between the present roles of doctors and of nurses. What would be the relationship of the nursing profession to such roles? In psychiatry, for example, I understand that nurses perform much more of the therapy than was formerly the case. One can raise a whole series of questions with regard to the possible future directions of change in the division of labor which provides medical service.

> The medical division of labor will continue to become greater, in that there will be more different kinds of things to be done and in that the health institutions will be more complicated and require more different kinds of people to operate them. In the course of this, physicians will learn more new techniques and will continue to reorganize their work by delegation to others, especially nurses, of many tasks and responsibilities. The preparation of operating rooms, the keeping of records and much scheduling, many actual procedures — once rare and now routine — have already been passed on. The doctor will keep control over the economy of his time by continuing such delegation, although, naturally enough, he probably will continue to complain that the woman to whom he delegates work and responsibility is not always there when he wants her on a moment's notice. The physician's work will become more and more difficult and demanding; he will ask for help and will get it — and probably have to pay for it in changes of behavior and position which he will not especially like.
>
> There will be more work for nurses to do, and more and more kinds of nurses will be required to do it. Some differences of opinion about the solution of the many resulting problems will be chronic, but people will continue to work at them. Research will be part of the effort.[2]

These questions can only be added to, or perhaps are among, the ones that nurses are already asking themselves. Maybe they can be researched and answered only within the sheltering ivory towers of a university professional school which should be free, to a large degree, of concern with the immediate problems of the field and concerned more with ultimate and perhaps useless-appearing investigations. Professional schools which foster this drive to increase knowledge, to reformulate values, and to enquire into the inner meanings and missions of professional work have a real contribution to make to university life. Those which cannot rise to this kind of challenge will be only a burden on the university. From their own point of view they might be better off elsewhere, where they would not have to suffer the snobbish attitudes of the scholarly researcher.

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Crazy or Courageous

M. Anne Sutherland, B.Sc.N.

There are, it may be, so many kinds of language in the world, and none of them is without signification. Therefore if I know not the meaning of the voice, I shall be unto him that speaketh a barbarian, and and he that speaketh shall be a barbarian unto me.—I Corinthians XIV:10, 11.

"How many of us whose native tongue is English would have the courage to seek work in a French hospital?"* After having spent a year working in a Quebec City hospital where the entire personnel was French-speaking, living with a French-Canadian family and attending evening courses at Laval University in order to improve my conversational ability in the French language, I may be qualified to answer this question. Using this personal experience as a background and as a starting point, bilingualism can be discussed as both a means and an end.

The fact that there is a relatively small group who is interested in learning the French language, is due to many factors. The need, the drive, the interest, the courage and the intellectual curiosity to acquire another language are not inherent in a nurse and furthermore, these are not being fostered by society. There tends to be a reciprocal relationship between these two factors, the end result being a state of almost complete inaction and linguistic lethargy. This inaction is typical of the nursing profession. The very thought of speaking French seems to be more foreign to and unpopular with this group than with many others. Almost every month there is an article in one of the leading magazines or daily papers stressing the importance of bilingualism in Canada today. Perhaps it is now time for the *vox populi* of nursing to raise on high the torch of the tongue with the lamp of healing.

Why are nurses not motivated to become bilingual? Every human being has basic needs and drives. Perhaps the need to speak more than one language is not important on a nurse's scale of valued, intangible possessions. And, why not? Most nurses can find satisfactory positions where English is the first language. If necessity is the mother of invention, perhaps she is also the parent of drive. Without the *need* for a second language, the drive to acquire one loses momentum and becomes dormant. A definite cause and effect relationship is evident. Complacency and self-satisfaction with a uni-linguistic state become dominant in the ego, while rejuvenation of the intellect and motivation decline as entities in the social being.

Similarly, since the need and drive are lacking, interest in bilingualism wanes or perhaps is not given a chance for cultivation. Quite likely this is a reversible reaction in that interest in

**The Canadian Nurse*, Jan. 1960, p. 4.

languages is the birthplace and departure point for the initial need and drive. The question can then be posed, was this interest ever present? Whether the answer is positive or negative, the plot thickens in an angular fashion.

If the interest has never been fostered, does it mean that our system of nursing education allows no contact with ideas and philosophies? Can a nurse's intellectual reach never exceed her grasp? If the interest was present it may have withered and died due to a lack of enthusiasm on the part of other members of society. How can the "old guard" cast off the shackles of traditionalism, so that a student's or a graduate nurse's curiosity may be stimulated toward cultural pursuits?

If the interest, drive and need to acquire a second language are present in a nurse, the courage to follow through in her endeavor, despite the apathy of her English-speaking counterparts, must be very strong. She will constantly meet queries of disbelief, horror and incredulity at the idea of embarking on such peculiar undertaking as seeking a position in so "foreign" an area as French Canada.

To counter these queries concerning her sanity, our Ulysses must have a certain love of the unusual, a desire to do something to escape the stereotype of her profession. This tinge of "craziness" is what will carry her through when the odds seem insurmountable — when humbleness becomes a virtue and man's greatest acquisition, the ability to express himself coherently, becomes her most dominant need and desire.

An exchange of students with the purpose of perfecting language capabilities has been in effect for many years in institutions of higher learning. Could such a "visite interprovinciale" be undertaken by nursing schools at both the graduate and undergraduate level?

In all aspects of life, it seems self-evident that if nothing is ventured, nothing is gained. The value of experience to be gained by living and working among a different ethnic group can not be over-estimated. One gains a broader and better understanding of people — an essential consideration if nurses are to develop and maintain an expansive and circumspect outlook toward the ever-increasing number of immigrants who are their potential patients. Too, a nurse can only truly realize how alone and how helpless a person feels when he is not among members of his own racial background, if she, too, has suffered from an inability to communicate verbally.

The sense of accomplishment which one achieves in learning a new language is almost beyond explanation. It is like opening a door into a new world. One must be familiar with the techniques of salesmanship in order to keep one's foot in the door, gradually forcing it open no matter how rusty the hinges or how temperamental the lock. Once the primary obstacles have been hurdled, the first three months of humility have passed, and the initial impulse is established, the barriers are swept away in a tide of exultation as one finds the vocabulary first, in order to *exist*, then to *converse* freely and finally, to *live* a finer, richer and fuller life with new friends and associates.

If the point of departure is drive, one must take the initiative in seeking a totally French milieu. The more English contacts one has the slower the progress. A constant need to think in French is required in order to conquer the initial think-translate-speak stage. One must have sufficient drive not to be dissuaded by the complacency of near-sighted English-speaking persons, which engenders the feeling that French is totally unnecessary in our modern society. One is constantly revitalized by the friendliness of the French-speaking people toward someone who is making the effort to learn their language and by the embarrassingly large number of French-speaking Canadians who speak perfect English.

Finally, what is bilingualism? Bilingualism is really a prerequisite to professional growth in Canada. The portals of understanding are unlocked by the language key. In this era of scientific advancement and emphasis on practicality, one can not afford to overlook the basic need of every individual to be understood and to communicate with his associates. Through the spoken language man can orient himself to his society and aid others in making the world a better

place for all. Is having a workable knowledge of another language then, not a practical necessity in this world of today? *Diplomacy* demands this courtesy. Why not extend it to other aspects of living?

Let's not be "ugly young nurses" who bungle at the bedside fumbling for phrases. Arise "angry young nurses." Let's stop talking shop. Let's start earning universal self-respect for our profession for reasons other than a tradition of unending service, indispensability and fatal availability. Let's start earning a place for ourselves in society as proponents of a "peace parley" as liberals, as advocates of cultural interests. *Let's be bilingual!*

You Haven't Got Your Bed Warm Yet!

GEORGE W. ISAAC

Acceptance of a problem is not possible without awareness of its existence.

I WAS RECENTLY discharged from a tuberculosis sanatorium, and while I would like to forget both my stay and the reasons that prompted it, I feel that there is a real need to air some of the problems of the one most concerned — the patient! I wish to record the good impressions in a spirit of tribute, and the bad ones in the hope that adverse criticism will be accepted as it is meant to be — constructive.

The new patient usually enters the sanatorium in a state of mild shock, which is manifested by his uneasiness and bewilderment at the strange environment. His unexpressed thought is "This can't be happening to me!" He knows that the usual hospital stay is for a short period, but now he is up against an unknown quantity — the indeterminate sentence!

Feeling like an unwilling performer in a grotesque charade, he gets into bed, has his temperature taken, his clothes taken, and most of his dwindling stock of self-confidence taken! At this point of low ebb a quiet and encouraging talk with an understanding "patient counsellor," preferably a layman, could have great influence on both the attitude and cooperation of the patient. Instead, he is confronted with a barrage of rules and regulations, then left to ferment in a lonely and alien atmosphere! Only a few hours before, he was a responsible member of society. Now, he feels himself reduced to the status of a guinea pig, complete with institutional and laundry numbers! Little attempt is made to express human understanding of the patient's anxieties.

Thus, the long days crawl by. The patient is constantly mulling over his private problems, always aware that if he could foresee the tentative termination of his stay, he could plan better for the future. While the physical care is excellent, regular progress reports are often sadly lacking. Worried about his family, home and business, how is his mind put at rest? He is told to relax, and often, to add to his already serious sense of frustration, is reminded that "You haven't got your bed warm yet!" This! After three or four months of increasing anxiety!

The new patient has two primary motives. One is to be cured and return home as quickly as possible; the other is to hold on to those things which meant security, once taken for granted, but now terribly important. He is aware that these are his own problems. He doubts that the institutional staff will be able to help him with them. This is when he feels the full impact of "the rules." Cut off from normal communication with home and business, he often acquires a growing sense of inadequacy which is relieved very little by "special permission" phone calls and visits that lack that essential requisite — privacy.

The rules, ever inflexible and often

stupid, may work more to the advantage of the staff and less to the benefit of the patient. Is this their purpose? The rules state that incoming telephone calls may only be answered by patients between 10:00 A.M. and 12 noon, 3:00 P.M. and 5:00 P.M., *if* the "routine" of the patient permits him to leave his bed. Consequently, many important personal calls are passed on to the patient after varying delays. Often the message is so garbled that he can scarcely understand it. Some patients would, if given more leeway, inhibit their own cure and cause a lot of unnecessary trouble for everyone, but is this a sound reason for penalizing those who "behave"?

I have seen close relatives, infrequent visitors because of the distance they must travel, treated with gross discourtesy because they lingered for several minutes after the bell had signalled the time of departure. Possibly they had not been there very long due to conditions of travel, and although no one would have been hurt by their staying a little longer, the attitude of some of the staff made it abundantly clear that they were then unwelcome. A frequent result was that the patient developed a distaste for the institution and all connected with it! Surely, anger and frustration offset the cure far more than the physical exertion of a walk to the telephone, or an occasional "bending" of other rules.

The majority of staff members are well chosen. Many of them are dedicated, most are cheerful and pleasant. It may be inevitable that there will be a few self-important, aseptic souls to whom the rule book is a Bible and the patient a statistic. For the edification of the latter, and as a lasting benefit to the patients, *all* staff members should be given periodic refresher courses in human relations. Would it be unrealistic to hope that the basic material for such a course might originate from the patient, rather than a psychologist who lacks the personal experience of the problems involved?

One of the most grievous aspects of sanatorium life is the almost complete lack of privacy. Unless a patient is on what is known as "ordinary routine" or better (usually months elapse before he attains it), all conferences with visitors are bedside affairs. The fact that business or family problems require private discussion, a thing impossible in a ward full of curious people, is disregarded. No provision is made for privacy nor would the "routine" permit a patient to make use of it if it did exist, unless he obtained special permission — sometimes hard to get even when the patient's physical condition is not a factor.

The peace of mind gained through a quiet talk would be far more beneficial to the patient than the callous disregard for its necessity and the deep frustration this causes. All infirmaries should have a suitable room for such occasions, which could be strictly out of bounds for other purposes. The head nurse could be given the authority to permit a patient to meet visitors for stated time periods, if the need is urgent to the patient and the privilege is not abused. The importance of such an arrangement lies in the fact that a visit of this nature can be quite unexpected, often when the doctor's permission is not readily obtainable.

There is too great a tendency to regard all criticisms as "beefs" stemming from neurotic persons. It should be remembered that the average patient in private life is just as capable of sound analysis of a given situation as is the doctor or the nurse in theirs.

While the medical profession may experience many setbacks in their attempts to overcome the disease, and the "cure" for tuberculosis is indeed a slow and trying process, it must be conceded that they are doing a wonderful job. Great advances have been made in the drugs used. Notable advances have been made in the realm of surgery. Operations that, even as recently as five years ago, had to be done in two stages are now completed in one, with little or no visible evidence. Even the most extensive procedures are becoming common due to the new and amazing techniques used.

Two decades ago there were no antibacterial substances available with which to fight tuberculosis. The main weapons were rest and diet. While there has been some relaxation in the rest regimen, one could reasonably ask at what stage does rest cease to be identified with cure? Granting the premise that the physical body, aided

by modern drugs, and revitalized by the removal of infected tissue together with adequate bed rest, should soon be restored to most of its former usefulness, we must still remember that man is more than a physical entity. Keeping in mind that he is also a vast complex of hopes, fears, likes, distastes, enthusiasms and boredoms, is rest allowed to become a fetish to the point where its benefits are submerged in a sea of restlessness and frustration?

Very little effort and less "institutional" thinking would make for great improvement. Could a start be made by replacing the flippant and negative "You haven't got your bed warm yet!" with "Keep your chin up, Mr. Jones, we'll try to get you home very soon!"

Visiting the Sick is an Art

CHRISTINA FIELD

When we are well we invite people to our homes at our convenience. When a person is sick, he may have a greater need for visitors, but the circumstances alter the factors that should be considered by a visitor.

A PATIENT'S visitor is a most important person. Perhaps I feel strongly about the visitor because so often after he or she has gone, the nurse is needed. This comes about for many reasons: the patient may be embarrassed and delays calling the nurse, or perhaps the visitor has stayed too long and the patient is fatigued and overwrought.

When a visitor arrives, the patient immediately becomes a hostess. We all know how exacting that role can be. She tries to be nice, make her visitor comfortable, while exerting her energies to entertain — to be pleasant for a period. Strain may be provoked in a patient who is not capable of responding to strain. This is one reason why a visitor should never sit down at the bedside, until the patient invites her to do so.

When the visitor has left, the nurse may have to relieve the strain, tension, or even the frustration that resulted from the visit. In this sense, visiting can be a real hazard to nursing.

Some visitors are inclined to ignore the following signs on a patient's door:

1. *No visitors* — that sign has a purpose.
2. *Patient sleeping* — that sign shows a need.
3. *Do not disturb* — the patient is "engaged."

These signs should convey the message that this is not the best, or a fitting time, to visit.

Another important element is the length of the visit. It should be short enough not to be exhausting, but long enough to satisfy the patient. An adequate visit will convey a feeling of well-being that comes from the realization that someone cares enough to take time and make the effort to come.

Each patient is different and, therefore, a different approach may be necessary. A pleasant manner is most important. It is devastating for a patient's morale to see a look of shock, pity, or even disgust or repulsion on the face of a visitor. Yet, there are situations that call forth these responses from us. A calm, pleasant approach in these circumstances can do much to make a hospital visit successful. Pleasantness is not a boisterous, happy-go-lucky approach that steals away the fine sense of kindness. Not many of us feel happy-go-lucky when we are lying flat on our backs, surrounded by tubes, bottles and gadgets of one kind or another!

We all like to receive gifts. We may not deserve them, we may not need them, but we do love to be given something.

One Thanksgiving our Couples' Club had decorated the church, and what to

do with the fruit posed a bit of a problem. So I took it to the hospital where I was night supervisor. I got some strawberry boxes and during the night, the staff filled them with fruit, and put one at the bedside of each patient. I'll never forget one old fellow — his eyes shining and bright, he was just thrilled! He had never had a box of fruit of his own before. He was so pleased he couldn't eat it!

I thought how careless I was about appreciating oranges, apples and grapes. They come so easily to some of us, we forget how seldom they come to others, especially those who have no family or friends. A visitor with a gift, though it may be very small, can do a tremendous job of conveying to the sick that feeling that all of us need so desperately of being loved enough that someone will give.

When we fulfil the responsibilities of visits to the best of our ability surely the Master will say, "Inasmuch as ye have done it unto one of the least of these my brethren, ye have done it unto me."

He Who Laughs, Lasts

DOROTHY M. DENT

There are many times in life when a sense of humor is of more value than anything else. To have it and use it can change your life, keep you healthy and add to the happiness of those around you.

THE FELLOW who lacks a sense of humor very often appears a fool. He makes mountains out of molehills and is beset by the trivialities of life. Man does away with many unimportant worries when he learns to laugh. If you are fortunate enough to have a sense of humor, cultivate it, use it, and allow it to grow. It not only snowballs in growth but it is contagious. Learn to laugh *with* others and *at* yourself. Recently, I did something that was so ridiculous that, had I not laughed, I would have taken myself off for psychoanalysis. The front door of my apartment building is opened by pressing the appropriate apartment bell and having the door released by a person within the apartment. One day as I was standing in the main lobby I saw a man rush outside, push a button and then try frantically to open the door. I watched him go through this performance four times. Because he had such a look of anxiety on his face I could stand it no longer. I opened the door for him from the inside and he exclaimed in frustration "There is something wrong with my buzzer. The door won't open!" Then, added "Would you try yours?" By this time some of his frustration had brushed off onto me. Without thinking I pushed my bell and to the man's amazement I burst out laughing. I said, "There is no one in my apartment." He looked at me blankly and said "There is no one in mine either!" We both laughed uproariously and his look of anxiety faded.

So much of the time our petty annoyances take on gigantic proportions because we take ourselves and the things that happen to us too seriously. We all have the pompous type of individuals among our acquaintances. They strut around but they stand precariously. They may have tasted success materially, but they have lost vibrant contact with people. They walk alone.

Ninety-nine times out of 100 a smile will be answered with a smile. It is much simpler than we think to be happy and gay. To know how and when to smile is a great gift. Good humor can be a simple therapy for many of our ills. We are told it relaxes muscles and unties many of the knots we get ourselves into emotionally and spiritually.

I know full well that life is a serious business but it need not be to the degree that we, ourselves, make it. Be-



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ware of the person who treats the insignificant and the important with equal gravity. He is as poorly adjusted to life as the one who treats these two life situations with equal levity. Someone who is always laughing could be dubbed a fool or an idiot. But, *he who never laughs is a knave.* If a man cannot learn how to laugh life's trivialities away, internal combustion caused by closeted tensions may make him explode. With the present day threat of high explosives *externally,* we would be wise to overcome the possibility of *inner explosion,* merely by sorting out life's values and putting aside the unimportant. Learn to laugh and you will be better able to meet those important periods of life and living that are bound to come to all of us some time.

Truly, he who laughs, lasts!

A theory has been advanced to explain the breathing difficulties in the very obese. The chest wall is much heavier in the obese person, therefore chest movement — breathing — demands greater effort. But although this effort is needed, it is not made. The very obese "protect" themselves against it through some mechanism of the nervous system — thus the characteristic breathing of the obese is shallow and irregular.

This breathing results in an uneven distribution of blood and air into the capillaries and alveoli of the lungs. Some of the alveoli may collapse and cease to function, which leads to incomplete oxygenation of blood. Vital organs do not receive all the oxygen they need to function properly; heart failure is one of the complications.

If the patients follow a very strict diet, they improve. After they have reduced, these abnormalities in their breathing disappear.

— American Heart Association

The concept of nursing diagnosis is a frightening one for most nurses to accept. Yet, we must face up to the responsibility that making a nursing diagnosis is an independent function of the professional nurse. Nursing diagnosis is defined as the determination of the nature and extent of nursing problems presented by individual patients, or families, receiving nursing care. The unique function of the professional nurse is conceived to be the identification or diagnosis of the nursing problem and deciding upon a course of nursing action to be followed for the solution of the problem.

— Faye G. Abdellah,
quoted in *NLN News,* Vol. 9, No. 4

* * *

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Staff Duty positions in private 428-bed hospital, non-registered graduates acceptable. Liberal personnel policies & salary. Write to: Personnel Director, Hospital of the Good Samaritan, 1212 Shatto Street, Los Angeles 17, California.

Graduate Nurses (Professional) We are an established teaching hospital offering a variety of interesting assignments in patient-centered care. The current starting salary for Staff Nurse is $390 per mo., for evenings $430 & nights $420 per mo., for a 40-hr. 5-day wk. Fringe benefits include paid vacation up to 4 wks. per yr., 8 paid holidays per year, cumulative sick leave, Blue Cross & pension plan available. The hospital is centrally located & offers private room accommodations in our modern nurses' residence. Your inquiries are invited: Director of Nursing Service, Department C.J.N., Mount Sinai Hospital of Chicago, 2750 West 15th. Place, Chicago 8, Illinois.

Staff Nurses 380 bed hosp. new 120 med-surg. unit. Trans. pd. 1st class air to Albuq. and return within U.S. in exchange for 1-yr. emp. contract. Come to New Mexico "Land of Enchantment." Career opportunities, largest pvt. JCAH accredited hosp. in state; near U. of New Mexico, R.N. & B.S. pgm. Practical Nurse pgm. accredited state & NAPNE. Vacancies, Med-Surg. & occasionally O.B., Peds., & O.R., salaries $315 per mo. even., night or O.R. with call; 6-mo. increases up to $375; days $300 per mo. with increases up to $360. Rotation from day duty is required only when no person desiring permanent P.M. or night tour is available. Liberal personnel policies include: optional Blue Cross, Discount Hosp. Services. pd. sick leave cumulative to 5 wks, annual physical exam., vacation 1 yr. — 2 wks., 2 yrs. — 3 wks. 5 yrs — 4 wks. Active inservice pgm. Occasional vacancy hosp. owned apts. New Mexico licensure as professional nurse & U.S. Citizenship (or Immigration Visa) required. Write or call collect: Mrs. Emily J. Tuttle, Dir. of Nursing, Presbyterian Hospital Center, 1012 Gold, S.E., Albuquerque, New Mexico. Phone 243-5611.

COURSES FOR R.N.'S N.Y. POLYCLINIC MED. SCH. & HOSP. — in heart of Manhattan — 6-mo. courses in: O.R. NURSING OPD. NURSING. MED.-SURG. NURSING. Classes 4 times yrly: Mar., June, Sept., Dec. Room, meals, Medical Care & monthly cash stipend. Positions available to graduates of our Courses. For information write: Director of Nursing Education, 345 W. 50 St., N.Y.C., NEW YORK.

Graduate Nurses for 450-bed non-sectarian acute General Hospital with NLN fully accredited school of nursing. Liberal personnel policies include tuition aid for study at Western Reserve University. Opening of new main building has created attractive positions for Staff Nurses in medical, surgical, obstetric & pediatric divisions. Apartments available in immediate neighborhood. Apply: Miss Louise Harrison, Director of Nursing Service, Mount Sinai Hospital, 1800 East 105th. Street, Cleveland 6, Ohio.

Staff Nurses: Exchange Visitor program offers opportunities to learn & earn at large modern tuberculosis hospital in convenient suburban Cleveland, Ohio. Start at $344 per mo. with semi-annual increments. 5-day work wk., paid vacation & 6 holidays, liberal sick leave, board, room & laundry at low rate in pleasant accommodations in nurses' home. Increase your professional experience at a progressive accredited hospital in an expanding community. Write: Director of Nursing, Sunny Acres Hospital, Cleveland 22, Ohio.

Registered Nurse (Scenic Oregon, vacation playground, skiing, swimming, boating & cultural events) for 295-bed teaching unit on campus of University of Oregon medical school. Salary starts at $372. Pay differential for nights & evenings. Liberal policy for advancement, vacations, sick leave, holidays. Apply: Multnomah Hospital, Portland 1, Oregon.

Staff Nurses (All Clinical Services) Base salary $319, differential for 3-11 and 11-7 shifts, liberal personnel policies include sick leave, retirement plan, 3-wks. vacation & laundry of uniforms. Orientation & in-service programs — housing available on campus or in vicinity of hospitals. Apply: Director of Nursing Service, The University of Texas-Medical Branch Hospitals, Galveston, Texas.

General Duty & O.R. Nurses for 210-bed General Hospital, start—days $355-$395, evenings $380-$420, nights $375-$415. O.R. starts $385. University city, postgraduate study at 2 universities, 40-hr. wk., 7 holidays, vacation, sick leave benefits, free Blue Cross hospital-medical insurance & $1,000 life insurance. Retirement program, extensive Intern-Resident educational program, living quarters available. Write: Personnel Manager, Virginia Mason Hospital, 1111 Terry Avenue, Seattle 1, Washington. 'Come to the Seattle World's Fair April 21 - October 21, 1962.

THE VANCOUVER GENERAL HOSPITAL

Appointments to nursing positions are available.

Good personnel policies in effect including medical welfare plan, 40 hour week — four weeks vacation. In-Staff Education program well established during winter months.

Salary $297 - $359 per month
with consideration for experience or special preparation.

Please apply to:

PERSONNEL DEPARTMENT,
10TH AVENUE AND HEATHER STREET,
VANCOUVER 9, BRITISH COLUMBIA.

JEWISH GENERAL HOSPITAL

MONTREAL QUE.



NURSING OPPORTUNITIES

In this modern 400-bed non-sectarian hospital in Administration, Teaching, Staff Nursing.

- Certified Nursing Assistants also required.
- Openings in all Clinical Services • Excellent personnel policies • Bursaries for post-basic courses in Teaching and Administration.

For further information, please write:

DIRECTOR OF NURSING, JEWISH GENERAL HOSPITAL, 3755 COTE ST. CATHERINE ROAD, MONTREAL, QUE.

CLINICAL INSTRUCTOR

in

PRINCIPLES AND APPLICATION OF OPERATING ROOM TECHNIQUE

Diploma in nursing education and experience in the operating room preferred.

This is a modern 300-bed hospital with plans now underway for expansion in 1962.

The school for nurses is well equipped and has a total enrolment of 94.

Apply to:

PERSONNEL DIRECTOR
SARNIA GENERAL HOSPITAL, SARNIA, ONTARIO

CHILDREN'S HOSPITAL OF WASHINGTON, D.C.

OFFERS

Registered Nurses a 16-wk. supplementary program in pediatric nursing. Admission dates, January 2, May 7, September 4, 1962; January 7, 1963.

For complete information write to:

DIRECTOR OF NURSING
2125-13th STREET, N.W., WASHINGTON 9, D.C.

THE CENTRAL REGISTRY OF GRADUATE NURSES TORONTO

Furnish Nurses
• **at any hour** •
DAY or NIGHT

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DIRECTOR OF NURSING POSITION OPEN

111-bed modern hospital in thriving community on Vancouver Island.

Apply with record of experience, training and references to:

H. E. Taylor, Administrator,
West Coast General Hospital,
Port Alberni, British Columbia.

OPERATING ROOM SUPERVISOR

Experienced with postgraduate training, for 140-bed new hospital. Good personnel policies, O.H.A. Pension Plan.

Enquire:

DIRECTOR OF NURSING,
ROSS MEMORIAL HOSPITAL,
LINDSAY, ONTARIO.

Registered General Duty Nurses in Northeastern Nevada, start $360 with regular increases, shift differential, meals, liberal personnel benefits. Write: Director of Nurses, General Hospital, Elko, Nevada.

Staff Nurses for 750-bed General Hospital. Liberal personnel policies, 40-hr. wk., opportunities for continuing education. Write to the: Department of Nursing, Hospital of the University of Pennsylvania, 3600 Spruce Street, Philadelphia 4, Pennsylvania.

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Operating Room Supervisor, qualified and experienced, for expanding General Hospital. Western Montreal suburb. Apply: Box "R", The Canadian Nurse Journal, 1522 Sherbrooke Street West, Montreal 25, Quebec.

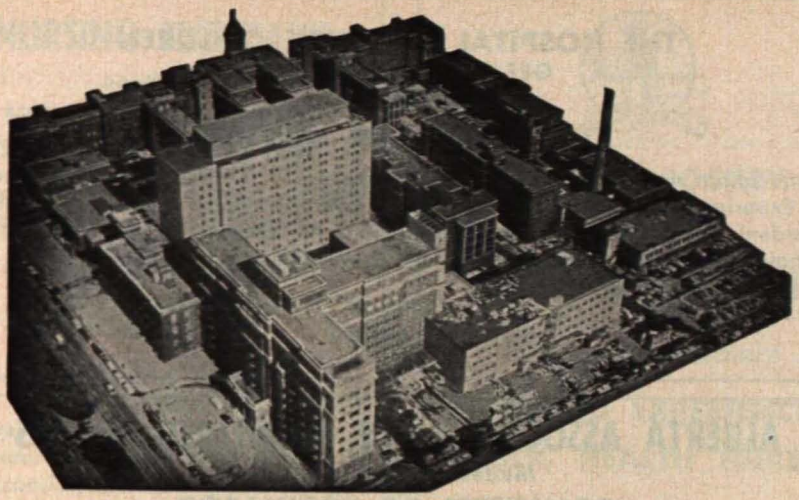
ONTARIO

Registered Nurse with administrative experience or university preparation in administration required for position of **Registry Director.** Apply stating salary expected to: Community Nursing Registry, Hamilton, Ontario.

Public Health Nurses (Qualified). Salary $3,900 - $4,875, annual increment $195. Transportation provided, the usual employee benefits. Apply: Dr. C. C. Stewart, Medical Officer of Health, 50 Centre Street, City Hall, Oshawa, Ontario.

MANITOBA

General Duty Nurses (3) for new 85-bed hospital. Good salary & generous personnel policies. Apply: Director of Nursing, Portage Hospital District #18, Portage La Prairie, Manitoba.



TORONTO GENERAL HOSPITAL

REQUIRES

Registered Nurses and Certified Nursing Assistants
for Medical and Surgical Services
including newly opened Neurosurgical and Cardiovascular Units
Rewarding Experience — Excellent Personnel Policies

For information write to:

Director of Nursing, Toronto General Hospital, 101 College Street, Toronto 2, Ontario.

GENERAL DUTY NURSES FOR ALL DEPARTMENTS

Gross salary $320 monthly with annual increments for 3 years to $350.

Until registration in Ontario is established — $295.

Rotating periods of duty — 40 hour week, 8 statutory holidays annually — Annual vacation 21 days after one year.

Annual sick time 12 days after one year, cumulative to 18 days. Hospitals of Ontario Pension Plan.

Ontario Hospital Insurance and Physicians' Services Incorporated, 50% payment by hospital.

Apply:

DIRECTOR OF NURSING, GENERAL HOSPITAL, OSHAWA, ONTARIO.

THE HOSPITAL FOR SICK CHILDREN
GREAT ORMOND STREET,
LONDON, W.C.1.

THE SCHOOL OF NURSING

Applications are invited from qualified female SISTER TUTORS, with an interest in Experimental Schemes of nursing education. Modern School of Nursing. Resident or Non-resident. Applicants from the Dominions or in receipt of Scholarships would receive sympathetic consideration.

Apply to:

MATRON

ALBERTA ASSOCIATION OF REGISTERED NURSES

Invites Applications for

COMMITTEE CO-ORDINATOR

To be the third member of the professional staff of Provincial Office. Broad knowledge of nursing service, nursing education and advanced preparation desirable. Duties will include co-ordination of activities of A.A.R.N. Committees. Salary based on experience and preparation. Personnel policies include pension plan.

Apply To: THE EXECUTIVE SECRETARY

ALBERTA ASSOCIATION OF REGISTERED NURSES
10256 - 112TH STREET — EDMONTON, ALBERTA.

WANTED IMMEDIATELY REGISTERED NURSES

FOR 35-BED HOSPITAL

Salary $305 with annual increments, allowance for experience and postgraduate training, 40 hour week — 9 statutory holidays, 3 week vacation after one year — 4 weeks thereafter, 1 day sick leave per month accumulative, generous fringe benefits, nurses' residence—board $45 per month.

Apply: **LITTLE LONG LAC HOSPITAL, GERALDTON, ONTARIO.**

CALIFORNIA - U.S.A.

invites you

Our beautiful modern 225-bed hospital situated in the Los Angeles area, only minutes away from the Pacific Ocean, welcomes inquiries from Canadian Registered Nurses interested in coming to our sunny land.

Please send inquiries to:
PERSONNEL DIRECTOR, DANIEL FREEMAN HOSPITAL,
333 NO. PRAIRIE, INGLEWOOD, CALIFORNIA.

DIRECTOR OF NURSES

Administrative/Education Training desirable. Administrative experience essential, 100-bed active, 31 Chronic; C.N.A. approved course.

Write to:

ADMINISTRATOR, PARRY SOUND GENERAL HOSPITAL
PARRY SOUND, ONTARIO (on Georgian Bay)

NEW BRUNSWICK

Registered Nurses for General Staff Duty in nursing services, medical & surgical nursing, also pediatrics. Applications & details furnished upon request. Please contact, Director of Nursing, Hotel-Dieu Hospital, Campbellton, New Brunswick.

NORTHWEST TERRITORIES

Operating Room Nurse with postgraduate course (immediately) for 44-bed hospital. Salary $305 plus $10 for P.G., $10 for 2 or more years of nursing experience, $25 full maintenance, air fare paid from Edmonton & transportation for 100 lbs. baggage. Apply: Director of Nursing, Stanton Yellowknife Hospital, Yellowknife, N.W.T.

NURSING SECRETARY

needed by

THE REGISTERED NURSES' ASSOCIATION OF NOVA SCOTIA

Our expanding program in nursing education and nursing service needs a well-qualified nurse to coordinate these activities with the school of nursing advisory program.

Qualifications: At least a bachelor's degree with preparation in nursing education and approximately ten years' experience in nursing education and nursing service.

For job specifications and personnel policies, apply to:

NANCY H. WATSON
EXECUTIVE SECRETARY, RNANS
73 COLLEGE STREET,
HALIFAX, NOVA SCOTIA.

SAINT JOHN GENERAL HOSPITAL,

Saint John, N.B.

requires a

SUPERVISOR

for

Pediatric Division

74-beds

A CLINICAL INSTRUCTOR

is responsible for

Student Program

For Information Apply To:

Director of Nursing

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For

CRIPPLED CHILDREN

Requires Immediately

QUALIFIED EXPERIENCED PUBLIC HEALTH NURSES

YOU WILL RECEIVE —

- GOOD SALARY RANGE
- A NEW AUTOMOBILE
- PENSION PLAN
- FREE INSURANCE
- 3-MONTH TRAINING COURSE

You will deal directly with children, their parents and service club members.

Apply to:

MISS SARA E. OLIPHANT REG.N.
SUPERVISOR OF NURSING
ONTARIO SOCIETY
FOR CRIPPLED CHILDREN
350 RUMSEY ROAD
P.O. BOX 1700, STATION "R"
TORONTO 17, ONTARIO.

REGISTERED NURSES
REQUIRED FOR DVA HOSPITALS

Salaries in accordance with accepted practice in the locality as indicated below. A higher rate may be paid for recent acceptable experience. Specialty allowances will be paid for postgraduate training or education which is utilized in the performance of the duties of the position.

Victoria Veterans Hospital, Victoria, B.C. ($3,600)
Shaughnessy Hospital, Vancouver, B.C. ($3,600)
Colonel Belcher Hospital, Calgary, Alta. ($3,450)
Deer Lodge Hospital, Winnipeg, Man. ($3,450)
Westminster Hospital, London, Ont. ($3,450)
Sunnybrook Hospital, Toronto, Ont. ($3,450)
Queen Mary Veterans Hospital, Montreal, P.Q. ($3,300)
Ste. Anne Veterans Hospital, Ste. Anne de Bellevue, P.Q. ($3,300)
Lancaster Hospital, Lancaster, N.B. ($3,150)
Camp Hill Hospital, Halifax, N.S. ($3,000)

BENEFITS:

Pension plan; three week's paid vacation; three week's cumulative sick leave; five day week. Cotton uniform and laundering of same will be provided. In some centres low cost living in staff residences is also available.

Applications are available at Civil Service Commission Offices, National Employment Offices and main Post Offices.

For further particulars contact the Civil Service Commission Office in the province where the position in which you are interested exists:

VANCOUVER, 1110 Georgia St. W., EDMONTON, 107 St. & 99 Ave., WINNIPEG, 266 Graham Ave., TORONTO, 25 St. Clair Ave. E., MONTREAL, 1165 Bleury St., SAINT JOHN, Canterbury St., HALIFAX, 105 Hollis St.

REGISTERED NURSES FOR GENERAL DUTY

in modern 20-bed hospital located in thriving Northwestern Ontario community. Starting salary $275 minimum to $325 maximum for three years' experience. Board and room in modern nurses' residence is supplied at no charge. Excellent employee benefits and recreational facilities available. Further particulars on request.

Apply, giving full details of experience, age, availability, etc. to:

EMPLOYMENT SUPERVISOR,
MARATHON CORPORATION OF CANADA LIMITED,
MARATHON, ONTARIO.

REGISTERED NURSES — CERTIFIED NURSING ASSISTANTS

Modern General Hospital, located in the Garden City of Canada, adjacent to American Cities and close to Toronto and Hamilton.

Good salary, 40 hour week with half-yearly increments — participation in Hospitalization, Pension, and Group Life Insurance — three weeks' vacation and Statutory Holidays.

Copy of Personnel Policy available on request.

Apply: **DIRECTOR OF NURSING SERVICE**
HOTEL DIEU HOSPITAL
ST. CATHARINES, ONTARIO.

THE PETERBOROUGH CIVIC HOSPITAL

REQUIRES

Administrative Supervisor for Operating Room

Instructor in Surgical Nursing

Instructor in Medical Nursing

For further information write:

THE DIRECTOR OF NURSING

PETERBOROUGH CIVIC HOSPITAL, PETERBOROUGH, ONTARIO

SUBURBAN TORONTO

GRADUATE NURSES & CERTIFIED NURSING ASSISTANTS

Are invited to enquire re: employment opportunities in a well-staffed expanding 125-bed hospital in suburban west Toronto. General Staff Nurses salary range: $305-$355 per mo. Certified Nursing Assistants $225-$255 per mo. 5 day week. Residence accommodation optional. Personnel manual forwarded on request. Enquire to:

DIRECTOR OF NURSING, HUMBER MEMORIAL HOSPITAL, 200 CHURCH STREET, WESTON, TORONTO 15, ONTARIO — CH. 4-5551

VICTORIAN ORDER OF NURSES FOR CANADA

has Staff and Supervisory positions in various parts of Canada.

Personnel Practices Provide:

- Opportunity for promotion.
- Transportation while on duty.
- Vacation with pay.
- Retirement annuity benefits.

For further information write to:

Director in Chief,
Victorian Order of Nurses for Canada
5 Blackburn Ave., Ottawa 2, Ontario

SCHOOL OF NURSING, CORNWALL GENERAL HOSPITAL

invites applications for positions of

INSTRUCTORS

This school conducts a progressive program for about 50 students, in connection with an active hospital of over 200-beds. A new wing will be occupied very shortly. Salary commensurate with experience and qualifications.

APPLY TO: **DIRECTOR OF NURSING**
CORNWALL GENERAL HOSPITAL, CORNWALL, ONTARIO

KINGSTON GENERAL HOSPITAL

has vacancies for

GENERAL STAFF NURSES

in Surgery and Medicine.

For personnel policies and further information, apply to:

DIRECTOR OF NURSING,
KINGSTON GENERAL HOSPITAL,
KINGSTON, ONTARIO.

GRADUATE NURSES

and

Certified Nursing Assistants

required for

FIVE SUMMER CAMPS

STRATEGICALLY LOCATED
THROUGHOUT ONTARIO
AND NEAR:
OTTAWA - LONDON
COLLINGWOOD
PORT COLBORNE
KIRKLAND LAKE

Apply in writing to:

Miss Helen Wallace, Reg'd N.
Supervisor of Camps
ONTARIO SOCIETY FOR CRIPPLED CHILDREN
350 RUMSEY ROAD
P.O. BOX 1700, STATION "R"
TORONTO 17, ONTARIO.

VICTORIA HOSPITAL
LONDON, ONTARIO

Modern 900-bed hospital
requires

Registered Nurses for all services

and

Certified Nursing Assistants

40 hour week - pension plan - good salaries and personnel policies.

Apply:

DIRECTOR OF NURSING
VICTORIA HOSPITAL
LONDON, ONTARIO.

OPERATING ROOM NURSES

General Staff Nurse positions available in General Operating Rooms (general surgical, cardiac, neuro-surgical, plastic, orthopedic, ear, nose and throat, and urology). Positions also in Gynecological and Ophthalmological operating rooms. Salary commensurate with experience, excellent additional benefits including refund of tuition up to six points per semester.

For further information write to:

DIRECTOR, NURSING SERVICE,
THE JOHNS HOPKINS HOSPITAL,
BALTIMORE 5, MARYLAND.

GRADUATE STAFF NURSES — YOU WILL LIKE IT HERE

Opportunities for men & women on the service of your choice. A 953-bed teaching hospital with a friendly atmosphere, well planned orientation program, active graduate nurse club, cultural advantages & excellent transportation facilities.

Starting salary: $325 per mo., 6 holidays, sick leave, 3 wk. vacation.

For further details write:

Director — Nursing Service, University Hospitals of Cleveland, Ohio.

NURSES

If you desire to practise your profession in a modern and scientific hospital, that has 21 specialties and 1,050 beds.

Join the nursing staff of

NOTRE DAME HOSPITAL

Generous salaries, according to qualifications, with periodic increases. Differential for evening and night duty, 10 Statutory holidays. Vacation based on date of employment. Pension plan. Inservice education program. Recreational Center.

For information, write to:

LA DIRECTRICE DU NURSING,
HOPITAL NOTRE DAME, 1560 EST, RUE SHERBROOKE, MONTREAL 24.

REHABILITATION INSTITUTE OF MONTREAL

110-bed new hospital, opening early 1962.

Positions available for:

BILINGUAL NURSES: Supervisors, Head Nurse for pediatric ward, General Duty Nurses.

BILINGUAL CERTIFIED NURSING ASSISTANTS.

Preference given to nurses having experience with paraplegics and hemiplegics. Excellent working conditions: pension plan, group insurance and other advantages.

For more information contact: **DIRECTOR OF NURSING SERVICE**
REHABILITATION INSTITUTE OF MONTREAL
6300 DARLINGTON AVENUE, MONTREAL, P.Q.

PSYCHIATRIC NURSING STAFF

required for

NEW MENTAL HEALTH DIVISION

of

ROYAL OTTAWA SANATORIUM

to open on or about March 1, 1962.

For further particulars write:

Director of Nursing,
Royal Ottawa Sanatorium, Ottawa, Ont.

ASSOCIATE DIRECTOR
of
NURSING SERVICE

434-bed General Hospital

with

School of Nursing

200 students

Good personnel policies.

Salary commensurate with preparation and experience.

Apply to:

DIRECTOR OF NURSING
ROYAL COLUMBIAN HOSPITAL
NEW WESTMINSTER, B.C.

Applications are invited for the position of

ASSISTANT DIRECTOR OF NURSING SERVICE

McKELLAR GENERAL HOSPITAL, FORT WILLIAM, ONTARIO.

Position will be open on April 1, 1962. Salary commensurate with qualifications and experience.

Apply to:

DIRECTOR OF NURSING, McKELLAR GENERAL HOSPITAL, FORT WILLIAM, ONTARIO.

OTTAWA CIVIC HOSPITAL

requires

GENERAL STAFF NURSES

for

OPERATING ROOM
MEDICAL
SURGICAL
OBSTETRICAL
& PSYCHIATRIC } DEPARTMENTS

Apply

EDITH G. YOUNG, REG. N., ASSISTANT DIRECTOR AND ADMINISTRATOR OF THE DEPARTMENT OF NURSING.

REGISTERED NURSES
AND
CERTIFIED NURSING ASSISTANTS

REQUIRED FOR

44-bed hospital with expansion program, 40-hr. wk. Situated in the Niagara Peninsula. Transportation assistance.

for salary rates & personnel policies
APPLY TO: DIRECTOR OF NURSING, HALDIMAND WAR MEMORIAL HOSPITAL, DUNNVILLE, ONTARIO

NORTHWESTERN GENERAL HOSPITAL

2175 KEELE STREET, TORONTO 15, ONTARIO.

requires

(1) **Head Nurse** — Infants section. Mature person with at least five years pediatric experience. Postgraduate preferred.

(2) **General Staff Nurses** for medical, nursery and postpartum areas.

Apply to: **ELLEN C. McLEAN, DIRECTOR OF NURSING.**

DIRECTOR OF NURSING

Required for a modern 26-bed hospital in northern Saskatchewan. Serving a community of 3,000. Salary to be negotiated. Private suite provided in modern residence, one month's annual vacation with transportation paid. Excellent personnel policies.

Please apply giving full particulars of training and experience to:

ADMINISTRATOR, MUNICIPAL HOSPITAL, URANIUM CITY, SASKATCHEWAN.

DIRECTOR OF NURSING

For modern General Hospital, expanding to 50-beds, 12 bassinets, completion in 1961.

Residence accommodation available.

Salary commensurate with experience and qualifications.

Apply giving full particulars of training and experience to:

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STRATFORD GENERAL HOSPITAL

STRATFORD, ONTARIO

requires

SUPERVISOR

Preferably with geriatric training and experience for a 100-bed long term hospital. Duties to commence immediately. Salary commensurate with qualifications and experience. Excellent personnel policies. O.H.A. Pension Plan. Stratford is a delightful city of 20,000 population, within easy reach of larger centres.

Apply: **THE DIRECTOR OF NURSING**
STRATFORD GENERAL HOSPITAL
STRATFORD, ONTARIO

GENERAL DUTY NURSES WANTED

Salary - $300 to $320 per month 40 hour week, no split shifts.

Vacation - 18 days plus 10 statutory holidays a year, 21 days sick leave cumulative from time of employment.

Transportation will be advanced if necessary.

Apply: Matron,
BERWYN MUNICIPAL HOSPITAL,
BERWYN, ALBERTA.

CANORA UNION HOSPITAL

CANORA, SASK.

requires

1. **INSTRUCTOR** for Student Nursing Assistants, duties to commence in February or in June 1962.
2. **GENERAL DUTY NURSES,** all departments.

For further information, apply to:
THE DIRECTOR OF NURSING
CANORA, SASKATCHEWAN

DIRECTOR OF NURSING

For active General Hospital (50-beds) with full complement of services. Building completed February 1961. Operating Room supervision experience essential. Salary commensurate with qualifications and experience.

Apply giving full particulars of training etc.
ADMINISTRATOR,
KIMBERLEY AND DISTRICT HOSPITAL,
KIMBERLEY, BRITISH COLUMBIA.

McKELLAR GENERAL HOSPITAL

FORT WILLIAM, ONTARIO

invites applications for:

(1) Clinical Instructor for Pediatrics.
(2) Clinical Instructor for Basic Nursing Course.
(3) General Staff — All services, including Operating Room.

Basic salary $285 — $325 per month with Ontario registration.

Apply to:
THE DIRECTOR OF NURSING,
McKELLAR GENERAL HOSPITAL,
FORT WILLIAM, ONTARIO.

JOSEPH BRANT MEMORIAL HOSPITAL

BURLINGTON, ONTARIO

Ideally located
- on the north shore of Lake Ontario
- six miles to Hamilton
- thirty miles to Toronto
- fifty miles to Niagara Falls
- excellent access to New York State

Friendly hospital and community
- hospital capacity 228 beds
- services: medical, surgical, pediatrics, obstetrics
- staff association
- active recreational program.

INQUIRIES ARE INVITED
WRITE TO THE
Director of Nursing.

REGISTERED NURSES

Head Nurse with postgraduate training, and Registered Staff Nurses, required for Operating Room Department in 120-bed General Hospital situated 12 miles west of Toronto. Good personnel policies including pension plan.

APPLY:
DIRECTOR OF NURSING
SOUTH PEEL HOSPITAL
COOKSVILLE, ONTARIO

REGISTERED NURSES
and
CERTIFIED NURSING ASSISTANTS

Are invited to enquire re: employment opportunities for all departments of new 140-bed hospital. Good personnel policies, O.H.A. Pension Plan.

Enquire:
DIRECTOR OF NURSING,
ROSS MEMORIAL HOSPITAL,
LINDSAY, ONTARIO.

EDUCATIONAL OPPORTUNITIES

DALHOUSIE UNIVERSITY

School of Nursing

Degree Course in Basic Professional Nursing
Candidates for the degree of Bachelor of Nursing are required to complete 2 years of university work before entering the clinical field, and one year of university work following the basic clinical period of 30 months. On completion of the course the student receives the **Degree** of Bachelor of Nursing and the **Professional Diploma** in either Teaching in Schools of Nursing or Public Health Nursing.

Degree Course for Graduate Nurses
Graduate nurses who wish to obtain the degree of Bachelor of Nursing are required to complete the three years of university work.

Diploma Courses for Graduate Nurses
(a) Public Health Nursing
(b) Teaching in Schools of Nursing
(c) Nursing Service Administration

For further information apply to:

DIRECTOR, SCHOOL OF NURSING
DALHOUSIE UNIVERSITY, HALIFAX, N.S.

UNIVERSITY OF BRITISH COLUMBIA

School of Nursing

DEGREE COURSE IN BASIC NURSING

DEGREE COURSE FOR GRADUATE NURSES

Both of these courses lead to the B.S.N. degree. Graduates are prepared for public health as well as hospital nursing positions.

DIPLOMA COURSES FOR GRADUATE NURSES

1. Public Health Nursing.
2. Administration of Hospital Nursing Units.

For information write to:

THE DIRECTOR, SCHOOL OF NURSING
UNIVERSITY OF B.C.,
VANCOUVER 8, B.C.

QUEEN'S UNIVERSITY SCHOOL OF NURSING

COURSES OFFERED

Undergraduate

Degree Course, 5 years leading to BNSc. Degree

Graduate Nurses

a. Degree Course, two years.
b. Diploma Courses, one year.
Public Health Nursing
or
Teaching and Supervision.

For information apply to:

DIRECTOR
SCHOOL OF NURSING,
QUEEN'S UNIVERSITY
KINGSTON, ONTARIO

SCHOOL FOR GRADUATE NURSES
McGILL UNIVERSITY

PROGRAMS FOR GRADUATE NURSES

Diploma

Students are granted a diploma at the completion of the first year of the program leading to the degree of Bachelor of Nursing. All first-year students elect to study in

— Public Health Nursing

OR

— Teaching and Supervision in one of the following:

- Medical-Surgical Nursing
- Psychiatric Nursing
- Maternal and Child Health Nursing

Degree of Bachelor of Nursing

A two-year program for nurses with McGill Senior Matriculation or its equivalent. A three-year program for nurses with McGill Junior Matriculation or its equivalent. In the first year students elect a field as indicated above. In the final year students elect to major in one of the following:

- Nursing Education
- Administration and Supervision in Hospitals or in Public Health Agencies

Degree of Master of Science (Applied)

A program of approximately two-years for nurses with a baccalaureate degree. Students elect to major in

- Development and Administration of Educational Programs in Nursing
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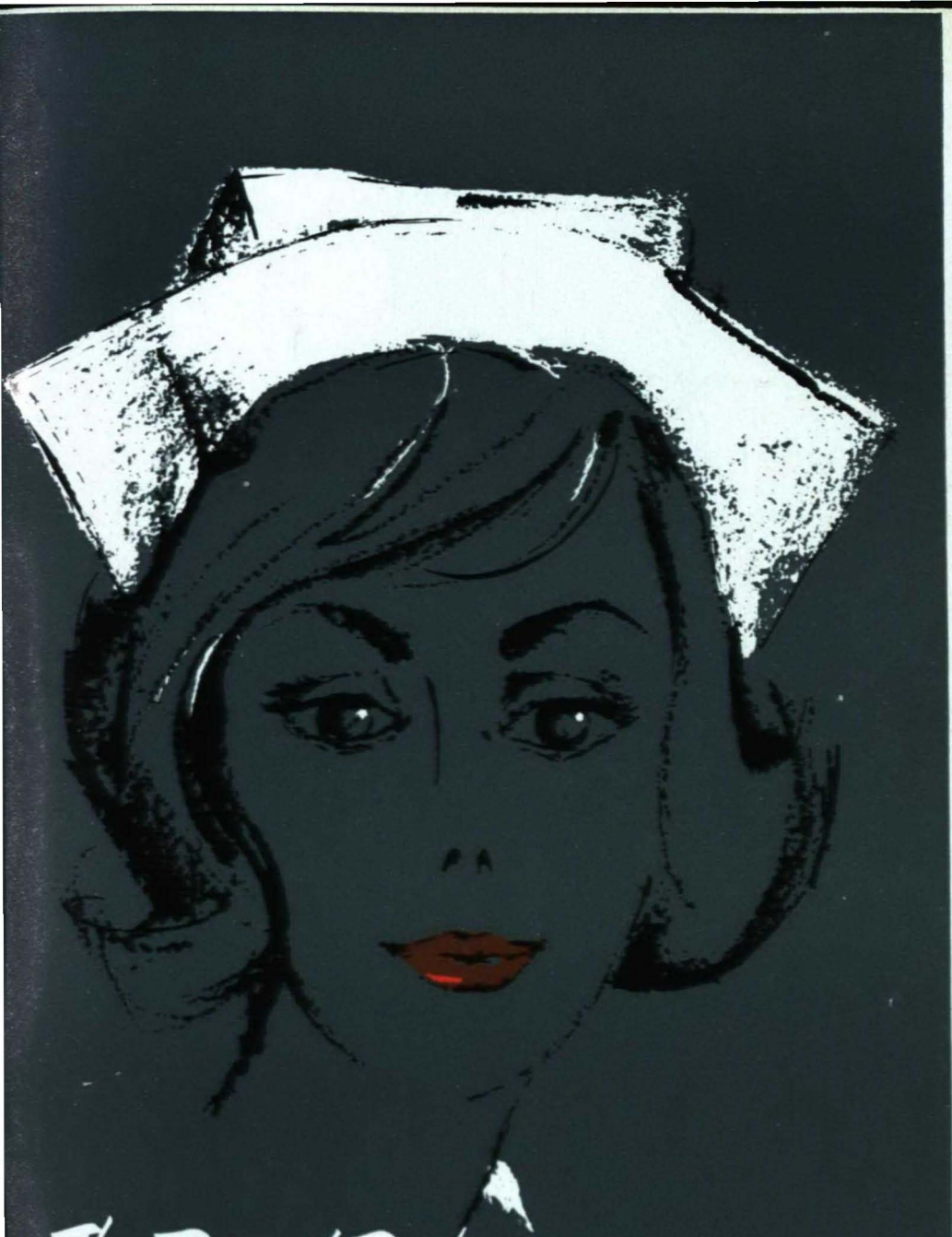
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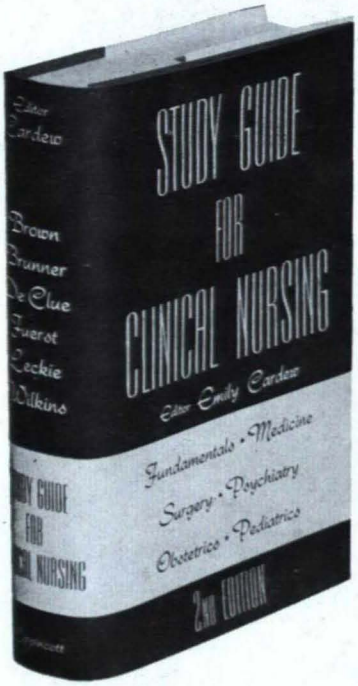
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